With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

**Trust Board (performance and monitoring)**
**Tuesday 29 March 2016 at 12:30**
**Rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR**

# AGENDA

**1. Welcome, introduction and apologies** (verbal item)

**2. Declaration of interests**

**3. Minutes and matters arising from previous Trust Board meeting held on 29 January 2016**

**4. Assurance from Trust Board committees**

4.1 Audit Committee 2 February 2016
4.2 Clinical Governance and Clinical Safety Committee 23 February 2016
4.3 Mental Health Act Committee 2 March 2016 (verbal update)
4.4 Remuneration and Terms of Service Committee 9 February 2016
4.5 Estates Forum 26 February 2016 (verbal update)
4.6 Equality and Inclusion Forum 8 March 2016 (verbal update)
4.7 Changes to Committee terms of reference

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

**6. Annual plan and budgets 2016/17 and annual plan submission to Monitor**

**7. Performance reports month 11 2015/16**

7.1 Performance report month 11 2015/16

7.2 Finance report month 11 2015/16

7.3 Exception reporting and action plans

(i) Safer staffing

(ii) Information governance toolkit

(iii) Eliminating mixed sex accommodation declaration

## 8. Governance matters

8.1 Annual Governance Statement

8.2 Decision-making framework

8.3 Calderdale Vanguard partnership agreement

## 9. Use of Trust seal

## 10. Date and time of next meeting

The next meeting of Trust Board will be held on Thursday 28 April 2016 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP.

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# Trust Board 29 March 2016
# Agenda item 2

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| **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:** | |
| **Executive summary:** | <u>Declaration of interests</u><br>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.<br><br>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.<br><br>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.<br><br><u>Non-Executive Director declaration of independence</u><br>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.<br><br><u>Fit and proper person requirement</u><br>There is a requirement for members of Boards of providers of NHS services |

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| | 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.<br><br>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 |

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# Trust Board – Declaration of Interests
# 29 March 2016

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 | Independent Non-Executive Director, Benenden Healthcare Society<br>Chair, Benenden Wellbeing<br>Chair, Keegan and Pennykidd<br>Non-Executive Director, Seedrs (with small shareholding)<br>Trustee and Director, NHS Providers<br>Chair, Family Fund (UK charity)<br>Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire<br>Private shareholding in Lloyds Banking Group PLC (retired member of staff) |
| **NON-EXECUTIVE DIRECTORS** | |
| Laurence Campbell | Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council |
| Rachel Court | Director, Leek United Building Society<br>Director, Invesco Perpetual Life Ltd.<br>Director, Leek United Financial Services Ltd. (from 27 April 2016)<br>Chair, PRISM<br>Governor, Calderdale College<br>Magistrate<br>Chair, NHS Pension Board |
| Charlotte Dyson | Independent marketing consultant, Beyondmc (marketing consultancy work for Royal College of Surgeons, Edinburgh)<br>Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional)<br>Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee<br>Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee<br>Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE |
| Julie Fox | Trustee and Advisory Board member, Peer Power (social justice organisation supporting young people) |

| Name | Declaration |
|---|---|
| | Employed by HM Inspectorate of Probation (to 30 June 2016)<br>Daughter appointed as Independent Hospital Manager |
| Chris Jones | Director and part owner, Chris Jones Consultancy Ltd.<br>Trustee, Children's Food Trust |
| Jonathan Jones | Member, Squire Patton Boggs (UK) LLP<br>Member, Squire Patton Boggs (MENA) LLP<br>Trustee, Hollybank Trust<br>Spouse, Company Secretary, Zenith Leasedrive Holdings Limited and its subsidiaries<br>Spouse, shareholder, Zenith Leasedrive Holdings Limited |
| **CHIEF EXECUTIVE** | |
| Steven Michael | Trustee and Treasurer, Spectrum People<br>Chair, NHS Confederation Mental Health Network<br>Trustee, NHS Confederation<br>Chair, Huddersfield University Business School Advisory Board<br>Partner, NHS Interim Management and Support (to 31 March 2016)<br>Health and Wellbeing Boards, Wakefield and Barnsley (to 31 March 2016)<br>Involvement in Care Quality Commission mental health inspection arrangements (to 31 March 2016)<br>Partner is employed by Mid-Yorkshire Hospitals NHS Trust |
| **EXECUTIVE DIRECTORS** | |
| Adrian Berry | No interests declared |
| Tim Breedon | No interests declared |
| Jon Cooke | No interests declared (although on secondment as Chief Finance Officer, Yorkshire and Humber Commissioning Support Unit) |
| Alan Davis | No interests declared |
| Alex Farrell | No interests declared |
| **COMPANY SECRETARY** | |
| Dawn Stephenson | Chair and Voluntary Trustee, Kirklees Active Leisure<br>Governor, Membership Council, Calderdale and Huddersfield NHS Foundation Trust (and member of Remuneration and Terms of Service sub-committee) |
| **OTHER DIRECTORS** | |
| Carol Harris | No interests declared |
| Kate Henry | No interests declared |
| Sean Rayner | Member, Independent Monitoring Board for HMP Wealstun<br>Trustee, Barnsley Premier Leisure |
| Diane Smith | No interests declared |
| Karen Taylor | No interests declared |

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# Minutes of Trust Board meeting held on 29 January 2016

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| **Present:** | Ian Black | Chair |
| | Laurence Campbell | Non-Executive Director |
| | Rachel Court | Non-Executive Director |
| | Charlotte Dyson | Non-Executive Director |
| | Julie Fox | Deputy Chair |
| | Chris Jones | Non-Executive Director |
| | Jonathan Jones | Non-Executive Director |
| | Steven Michael | Chief Executive |
| | Adrian Berry | Medical Director |
| | Tim Breedon | Director of Nursing, Clinical Governance and Safety |
| | Jon Cooke | Interim Director of Finance |
| | Alan Davis | Director of Human Resources and Workforce Development |
| | Alex Farrell | Deputy Chief Executive |
| **Apologies:** | None | |
| **In attendance:** | Dawn Stephenson | Director of Corporate Development (Company Secretary) |
| | Bernie Cherriman-Sykes | Board Secretary (author) |
| **Guests:** | Nasim Hasnie | Publicly elected governor (Kirklees), Members' Council |
| | Bob Mortimer | Publicly elected governor (Kirklees), Members' Council |
| | Jo Sygrove | Engagement Officer, HealthWatch, Calderdale |



## TB/16/01 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular, Jon Cooke (JC) attending his first meeting as Interim Director of Finance. There were no apologies.

## TB/16/02 Declaration of interests (agenda item 2)

The following declaration was made over and above those made in April 2015 and subsequently.

| Name | Declaration |
|---|---|
| **EXECUTIVE DIRECTORS** | |
| Jon Cooke | No interests declared although on secondment as Chief Finance Officer, Yorkshire and Humber Commissioning Support Unit |

There were no comments or remarks made on the Declaration; therefore, **it was RESOLVED to formally NOTE the Declaration.**

## TB/16/03 Minutes of and matters arising from the Trust Board meeting held on 22 December 2015 (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 22 December 2015 as a true and accurate record of the meeting.** There were no matters arising.

## TB/16/04 Assurance from Trust Board committees (agenda item 4)

TB/16/04a Information Management and Technology Forum 5 January 2016 (agenda item 4.1)

The key points raised and discussed were noted.

## TB/16/05 Chair and Chief Executive's remarks (agenda item 5)

IB began by updating Trust Board on the process to appoint a new Chief Executive. Shortlisting takes place after today's Trust Board meeting following an evaluation of longlisted candidates by Harvey Nash. The formal interview process takes place on 10 and 11 February 2016 with a series of meetings with stakeholder groups on 10 February 2016 (service users and carers, senior clinical staff, senior staff and staff side representatives, and Non-Executive and Executive Directors). This will be followed by a formal interview on 11 February 2016. The interview panel will consist of Ian Black, Chair of the Trust (and Chair of the interview panel), Julie Fox, Deputy Chair of the Trust, Stephen Dalton, Chief Executive, Mental Health Network, NHS Confederation (External Assessor), Michael Smith, publicly elected governor for Calderdale and Lead Governor, and Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group. The Members' Council will be asked to ratify the appointment at its meeting on 12 February 2016.

IB went on to congratulate Paula Phillips, Service Manager/Nurse Consultant in Forensic Child and Adolescent Mental Health Services (CAMHS), who was honoured in the New Year's Honours with a MBE. The Trust's previous Medical Director, Nisreen Booya, was also honoured with a MBE for services to healthcare, particularly mental health.

He also commented on a recent NHS Providers Board meeting where its strategy for the next twelve months was reviewed. It is clear that this is a very challenging environment for the NHS as a whole and for the trade body that represents NHS provider organisations. IB also attended an engagement event for Chairs on the bringing together of Monitor and the NHS Trust Development Agency as one organisation under the name NHS Improvement. The event set out the objectives, aims and approach of the new organisation as well as the planned structure and forward strategy; however, that this is to be implemented against a 30% reduction in budget is a potential cause for concern.

The Chief Executive (SM) covered the following in his remarks.

- The Prime Minister has repeated his message that mental health is a priority for the NHS; however, the Department of Health has since confirmed there will be no additional funding. The Trust will, therefore, have to strongly negotiate a fair apportionment for mental health to support the commitment to parity of esteem. The Trust will work with commissioners to ensure there is no reduction in Trust funding, which will be a challenge. This is not just a Trust issue; it is part of a multi-agency and partnership approach affecting many other organisations. Parity of esteem was also a key issue for discussion at the recent NHS Confederation Mental Health Network meeting.
- SM and Tim Breedon (TB) met with the Care Quality Commission (CQC) in advance of its inspection, which will take place in the week beginning 7 March 2016. The inspection will be chaired by Dr Paul Lelliott, the CQC's Deputy Chief Inspector of Hospitals (mental health) and a consultant psychiatrist by background. The inspection lead will be Jenny Wilkes, Head of Hospital Inspection (mental health). In advance of the inspection, the CQC will ask a range of stakeholders for feedback about the Trust and its services and, during the inspection itself, the team will visit all mental health wards, a third of mental health community teams and a cross-section of general community services. The inspectors will be looking for clinical care to carry on as normally as possible. The CQC does appreciate, however, that the visit places an extra burden on services and inspectors expect the Trust to have additional staff on duty to accommodate the visit. This will enable inspectors to spend time talking to as many staff as possible, without causing too much disruption to services. The CQC will expect the Trust to show what it does well as well as looking at more challenging areas of Trust services where the focus will be on how well the Trust manages such situations for the benefit of the people who use its services. The Trust expects to receive the draft reports in May 2016 to comment

for factual accuracy before the reports are published in June 2016. A Quality Summit event will be held over the summer.

- SM went on to comment that the consultation on accident and emergency services provided by Calderdale and Huddersfield NHS Foundation Trust (CHFT) will have implications for the Trust although it is unlikely that the Dales, where in-patient mental health services are provided by this Trust in Calderdale, will be included in the re-configuration plans. He added that the urgent and emergency care system is currently under serious pressure with a 'gold command' process instigated. The Trust is linked into the process through Karen Taylor.

Jonathan Jones (JJ) asked about the timescales for the Chief Executive's appointment in relation to the CQC inspection. IB responded that it is the intention to make an appointment on 11 February 2016 for the Members' Council to ratify on 12 February 2016; therefore, the Trust will have made a substantive appointment by the time of the CQC inspection. Alan Davis (AGD) added that the appointment will be subject to references and the outcome of employment checks, including the Fit and Proper Persons' Test, and any need to seek Treasury approval for the level of remuneration. IB went on to advise that he would hope to have an individual in post by mid- to end of May 2016.

JJ also sought assurance regarding the appointment of a substantive Director of Finance. IB responded that it is intended that the new Chief Executive will be involved in shortlisting and will chair the interview panel. JJ went on to ask if the new Chief Executive would be in place to 'own' the CQC report and any action plan arising from the inspection. IB confirmed that they would and this would be a priority in the first few months following appointment.

JJ went on to ask about the standing of the strategic direction agreed by Trust Board. IB responded that there has to be a balance between Trust Board setting the strategic direction and the ability of a new Chief Executive to influence this. The strategic approach will be a key area for the interview panel to probe on 11 February 2016.

Chris Jones (CJ) asked about the implications for the Trust in the longer-term from the positon with CHFT. SM responded that it is imperative that the Trust seeks a fair funding settlement from commissioners. Whilst the Trust is supportive of its acute provider partners, it must not be to the detriment of this Trust's services or its plans.

## TB/16/06 Strategic overview of business and associated risks (agenda item 6)

Alex Farrell (AF) took Trust Board through the key strategic business and associated risks, particularly the challenges at national and regional level. JC outlined the priority areas identified at national level to turn the forecast deficit position around. He assured Trust Board that, for this Trust, it is business as usual as the Trust is looking at these areas already. SM commented that this is a very interesting situation and demonstrates greater control centrally; however, this Trust is a foundation trust and must continue to maximise its use of resources to meet its aims and objectives for the benefit of the care it provides to people who use its services.

AF went on to comment that capital to revenue transfers will pose problems for Trusts and auditors in terms of fundamental accounting principles. She reminded Trust Board that the Trust had been asked to identify any flexibility in its capital programme and that it had offered Monitor £500,000; however, this has not been taken up. She assured Trust Board that this would have had no effect on Trust finances as the funds would be returned through a reduction in the Public Dividend Capital payment (although she was unsure how this would be achieved). Monitor has since indicated that the focus currently is on Trusts with major

deficit positions. The Trust, therefore, will not seek to follow up the offer. AF then outlined the impact on risk and IB asked for comments and questions from Trust Board.

- IB began by commenting that the financial position is dominating the NHS agenda and asked whether other areas were suffering as a result. AF responded that use of bank and agency to achieve safer staffing levels is driving financial and recruitment pressures currently. SM added that the Trust's prime objective is the quality and safety of its services. TB added that as 'balancing the books' becomes harder, the Quality Impact Assessment process becomes even more important to ensure the safety and quality of Trust services and to maximise efficiency and productivity gains; however, at some point, the Trust will have to consider its discretionary activity and be clear what it is providing, how and how its resources are utilised to achieve this.
- Supporting Charlotte Dyson's (CD) comments that the Trust needs to be clear on its service offer and ensure this is clear in the health and social care economy, AF commented that the Trust needs to be clear on its service offer, robust in its negotiations with commissioners to get the best offer and manage opportunities to ensure it provides the best quality services safely, effectively and efficiently.
- TB commented that, whilst the Trust may manage its own risk and implications, it has to be mindful of the risk and challenges in the wider system. This also needs to be discussed with commissioners.
- JJ asked if there were any clinical or reputational risks for the Trust in terms of partnerships with 'failing' organisations. AF responded that the sustainability of an organisation is part of the assessment of whether to partner or not. There is currently no indication that this is the case with any of the Trust's partners.
- Julie Fox (JF) asked about the impact of competition, particularly that from the private sector. AF responded that competition is particularly strong in the forensic sector, where there is a high level of private sector investment; however, this is affected by a concern about national commissioning intentions. Competition also applies to health and wellbeing services and Tier 4 CAMHS. The impact will also be felt in the third sector and there will be a need for some form of co-ordination to ensure people are signposted to the services they need.

AF then outline the key internal risks for the Trust in relation to sustainability of cost savings delivery, predicted shortfall in CQUIN income, alignment of transformation work with the requirements of the annual plan, ensuring appropriate focus and participation in system-wide transformation, ensuring the Trust is prepared for the 2016/17 contracting round and the impact of bid activity and mobilisation on day-to-day services.

AGD commented that, in relation to workforce, the Trust must ensure that the focus is on quality, particularly at the front-line. The need for change is widely accepted and the workforce will be based on a very different model with very different ways of working in future. The wellbeing and engagement agenda for staff remains a top priority for the Trust. Further work is needed on workforce plans, particularly in terms of the radical change needed to support transformation.

## TB/16/07 Performance reports month 9 2015/16 (agenda item 7)

TB/16/07a Quality performance report (agenda item 7.1)

IB invited comments from Trust Board.

- CD asked for an update on improving access to psychological therapies. AF responded that the data collection has been reviewed and the position has improved as a result. For 18 weeks, the Trust has achieved 99.37% against a target of 95%. For six weeks, the Trust has achieved 71.6% against a target of 75%. Under-performance on this target raises concerns if the Trust reports non-achievement in three consecutive quarters. The

under-performance relates to difficulties with staff capacity and recruitment; however, the indication from a review of January 2016 data is that the six-week access target is on target to be achieved in month 10 presenting no long-term concern.

- JF commented that the vacancy rate is still missing from the report. AGD agreed to follow this up for next month's report.
- AGD also confirmed that a detailed analysis of sickness absence would be presented to the Remuneration and Terms of Service Committee on 9 February 2016.
- IB asked why there was such a large proportion of 'don't know' in terms of recommending the CAMHS to friends and family. Dawn Stephenson (DS) responded that sometimes users of Trust services do not feel able to determine whether they would recommend services. IB commented that this does not appear to be the case for other Trust services. He asked DS to establish the reasons for this and report back to Trust Board.
- CJ added that 12% of people responding 'not likely' to recommend CAMHS does not provide much assurance. SM responded that without understanding the figures by district and service, it makes it very difficult to interpret and to come to conclusions. He felt a more detailed analysis would be useful as it was not clear from the figures what, if anything, Trust Board should be concerned about. Adrian Berry (ABe) added that the high response rate for CAMHS is also interesting. JF also asked for the detailed review to include trend information to demonstrate improvement. It was agreed that a full report on the Friends and Family Test by district and service, with benchmarking information and trends should be presented to the Clinical Governance and Clinical Safety Committee. This should also include a detailed analysis of the staff Friends and Family Test outcome.
- SM commented that he would like to see a more detailed report on progress with supporting service users into employment and a briefing for Trust Board on improving access to psychological therapies across all districts whether provided by the Trust or not. He was happy for this to be presented to the Clinical Governance and Clinical Safety Committee but should also be circulated to all members of Trust Board.

<u>TB/16/07b Finance report (agenda item 7.2)</u>
JC highlighted the following.

- The year-to-date position at month 9 is a £200,000 surplus, which is £90,000 ahead of the Trust's revised plan.
- Following a thorough review of the forecast and provisions, JC was confident that the Trust would deliver the revised forecast position (£100,000 surplus).
- There was also a positive indication that the Trust will realise the receipt from the sale of Aberford field in this financial year.
- The capital spend to December 2015 is £7.82 million, which is £0.6 million (7%) behind plan; however, there is confidence the outturn position will be realised.
- At December 2015, the cost improvement position is £890,000 behind plan. Overall, a full value of £1.4 million (15%) has been rated 'red'; however, this position is included in the reported position for month 9 and does not, therefore, pose an additional risk.

Laurence Campbell (LC) commented that the release of provisions at month 9 has helped the overall position. He also asked if JC was comfortable with the impairment position. JC responded that this was still to be worked through but he was comfortable that the reduced valuation of the Fieldhead site would be compensated by an overall increase in the value of other Trust estate with no impact on the bottom line.

LC commented that he still had a concern about the continuing issue with payment of an invoice to one particular local authority. JC agreed to provide an explanation to LC outside of the meeting.

TB/16/07c Customer services report (agenda item 7.3)
DS asked for feedback on the revised presentation of information.

JF asked why it took so long in some cases to allocate a lead investigator. DS responded that this largely relates to capacity and availability of staff within BDUs. Work is ongoing to improve the position.

TB/16/07d Exception reports and action plans – Potential implications for the Trust arising from Southern Health NHS Foundation Trust concerns (agenda item 7.4(i))
TB introduced the paper. SM commented that, in relation to communication and contact with families, the customer services report supports the investment the Trust makes. The Patient Safety Support and Customer Services teams work closely together to engage with families.

JJ commented that this was an excellent paper and he derived comfort and assurance from it.

CJ asked whether the Trust should do more than supported reading. TB responded that supported reading often results in other support or signposting to alternative advice and guidance. ABe added that families are involved at the start of and throughout the investigation process and in forming the recommendations as a result.

CJ asked if there was anything for the Trust to learn from the Southern Health report. TB responded that there was nothing new as such; however, there has been a sharper focus on thresholds for reporting. There may also be some recommendations that come back to all Trusts from the Department of Health.

IB commented that the paper focuses on service users in contact with Trust services; however, there are serious incidents that occur, for example, suicides, where there has been no contact with Trust services. The paper provides reassurance for this Trust but he was still concerned about other incidents. He asked if there was anything missing from the Trust's referral processes for example. TB reminded Trust Board of the ongoing discussion with Coroners, taken as a first step to gather more information on incidents outside of Trust services. Development of a suicide prevention strategy through the Urgent and Emergency Care Vanguard will help to develop a system-wide approach. SM added that development of the health intelligence manual will provide information on the wider system position, which will help inform commissioning approaches. TB suggested taking into the Clinical Governance and Clinical Safety Committee for a more detailed discussion.

**It was RESOLVED to NOTE the assurance provided in the report.**

TB/16/07e Exception reports and action plans – Care Quality Commission inspection preparation plan (agenda item 7.4(ii))
**It was RESOLVED to NOTE the report.**

TB/16/07f Exception reports and action plans – Governance arrangements – arm's length organisations (agenda item 7.4(iii))
**It was RESOLVED to NOTE the report.**

## TB/16/08 Items for approval (agenda item 8)

TB/16/08a Risk management strategy (agenda item 8.1)
A number of areas for clarification had been raised in the risk management training prior to the formal meeting. These will be reviewed and included as appropriate. LC asked that the aim to minimise risk includes a statement that this would be dependent on resources and

that the statement on risk appetite needed to be clearer. Rachel Court (RC) added that she would like to see an overarching statement on the appetite for risk such as cautious or neutral with some key risk indicators for levels of different types of risk.

**It was RESOLVED to APPROVE the strategy subject to the consideration and inclusion of the comments made.** Trust Board delegated authority to SM to approve the final version.

TB/16/08b Customer services policy (agenda item 8.2)
**It was RESOLVED to APPROVE the policy.**

## TB/16/09 Board self-certification and assessment of operational, clinical and quality risks (agenda item 9)

DS outlined the additions to be made to the quarter 3 to Monitor. LC asked whether there was a concern at the increase in the risks identified by the CQC in its Intelligent Monitoring report. TB responded that seven risks are now shown. One elevated risk relates to a risk that the CQC will remove. The Trust has questioned two areas of risk identified with the CQC as the data appears to be incorrect.

JJ commented that there are a number of vacant seats on the Members' Council. He asked what the Trust intends to do to attract people to stand. DS responded that the Trust is working with Electoral Reform Services to communicate and engage with members and to use examples of best practice. The Members' Council also has a role to engage and encourage individuals to stand for election. JJ commented that he would like to see a concerted social media effort to attract individuals. IB added that there is a natural turnover within public governors and people do stand for re-election; however, it will make for stronger representation to fully appoint to the vacancies.

**It was RESOLVED to APPROVE the submission and exception report to Monitor.**

## TB/16/10 Assurance framework and organisational risk register (agenda item 10)

DS invited comments from Trust Board on the assurance and escalation framework.

The revised version of the assurance framework was welcomed and seen to be a good way to document the current position in relation to assurance and risk.

It was agreed to add a risk in relation to the implementation of RiO V7. IB asked if there was sufficient reflection of the external environment in the risk register. There was a general consensus that there was and DS advised that this is discussed in detail by both Trust Board and the Executive Management Team.

RC asked how the target levels for mitigated risk reflected the Trust's risk appetite. CJ felt that it reflected the fact that there are occasions where a risk level has to be tolerated or accepted.

**It was RESOLVED to NOTE the controls and assurances against corporate objectives for 2015/16, to SUPPORT the assurance and escalation framework, and to NOTE the organisational risk register.**

**TB/16/11 Date and time of next meeting (agenda item 11)**

The next meeting of Trust Board will be held on Tuesday 29 March 2016 in rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR.

**Signed …… Date ……**

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NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 4 – assurance from Trust Board Committees

## Audit Committee

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| **Date** | 2 February 2016 |
| **Presented by** | Laurence Campbell |
| **Key items to raise at Trust Board** | ➢ Internal audit reports – patient's property, service line agreements and job planning (although the Committee noted that the final report has not yet been agreed with management).<br>➢ External audit plan and timetable.<br>➢ Quality Accounts local indicator. |

## Clinical Governance and Clinical Safety Committee

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| **Date** | 23 February 2016 |
| **Presented by** | Julie Fox |
| **Key items to raise at Trust Board** | ➢ Development of the Trust's Suicide Prevention Strategy.<br>➢ Child and Adolescent Mental Health Services.<br>➢ The implementation of an upgrade to the Trust's clinical information system, RiO.<br>➢ Care Quality Commission Mental Health Act visits to Trust services.<br>➢ The briefing note on waiting times for Improving Access to Psychological Therapies.<br>➢ Quality impact assessment of cost improvement programme. |

## Mental Health Act Committee

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|---|---|
| **Date** | 2 March 2016 |
| **Presented by** | Julie Fox |
| **Key items to raise at Trust Board** | ➢ Presentation on the positive outcome of a review of Mental Health Act audits undertaken between 2012 and 2015, which demonstrates a number of areas of improvement.<br>➢ Care Quality Commission annual mental health briefing (a summary of its Mental Health Act visit activity across all mental health trusts), which sets out a number of areas for attention. The Committee was assured that the Trust has these areas in its plan for review.<br>➢ The impact of transformation of Trust services on the application of the Mental Health Act will be included in the Committee's work plan for 2016. |

## Remuneration and Terms of Service Committee

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| **Date** | 9 February 2016 |
| **Presented by** | Ian Black |
| **Key items to raise at Trust Board** | ➢ Changes to pension arrangements at national level.<br>➢ Sickness absence.<br>➢ Ratification of Clinical Excellence Awards.<br>➢ Update on appointments at Director level. |

## Estates Forum

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| **Date** | 26 February 2016 |
| **Presented by** | Jonathan Jones |
| **Key items to raise at Trust Board** | ➢ Capital plan 2015/16 and 2016/17.<br>➢ Development of community hubs.<br>➢ Development of non-secure estate on the Fieldhead site.<br>➢ Castleford, Normanton and District Hospital site. |

## Equality and Inclusion Forum

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| **Date** | 8 March 2016 |
| **Presented by** | Ian Black |
| **Key items to raise at Trust Board** | ➢ Equality Workforce Annual Report 2015.<br>➢ Workforce Race Equality Standard.<br>➢ Revised training offer. |

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Minutes of Audit Committee held on 2 February 2016

| | | |
|---|---|---|
| **Present:** | Laurence Campbell | Chair of the Committee |
| | Chris Jones | Non-Executive Director |
| | Jonathan Jones | Non-Executive Director |
| **Apologies:** | Members | |
| | None | |
| | Others | |
| | Mark Dalton | Manager, KPMG |
| | Mark Johnson | Interim Deputy Director of Finance |
| **In attendance:** | Rob Adamson | Head of Finance |
| | Ian Black | Chair of the Trust |
| | Bernie Cherriman-Sykes | Integrated Governance Manager (author) |
| | Jon Cohen | Senior Manager, KPMG |
| | Jon Cooke | Interim Director of Finance |
| | Tony Cooper | Head of Procurement |
| | Sue Cordon | Clinical Lead, KPMG |
| | Charlotte Dyson | Non-Executive Director |
| | Paul Hewitson | Director, Deloitte |
| | Clare Partridge | Director, KPMG (Head of Internal Audit) |
| | Dawn Stephenson | Director of Corporate Development |
| | Karen Taylor | District Director, Calderdale and Kirklees (for item 3.3) |
| | Paul Thomson | Partner, Deloitte |

## AC/16/01 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (LC) welcomed everyone to the meeting, in particular, Jon Cooke (JC), attending his first meeting as interim Director of Finance. The apologies, as above, were noted.

## AC/16/02 Minutes of the meeting held on 6 October 2015 (agenda item 2)

**It was RESOLVED to APPROVE the minutes of the Audit Committee held on 6 October 2015 as a true and accurate record of the meeting.**

## AC/16/03 Matters arising from the meeting held on 6 October 2015 (agenda item 3)

AC/15/11 Annual penetration testing of IT systems (agenda item 3.1)

The Committee noted that this had been scheduled to follow the RiO V7 upgrade; however, due to recent issues with the implementation of RiO V7, the testing has been delayed. It will be re-scheduled; however, the Trust is not in a position to confirm the timing of this as yet.

AC/15/74 Improving the quality of clinical information (agenda item 3.2)

The update paper was noted.

AC/15/80 Patients' property internal audit report – update on implementation of recommendations (agenda item 3.3)

Karen Taylor (KT) took the Committee through the action taken to address the recommendations made by KPMG. The findings of the 'mini audit' were noted by the Committee. Clare Partridge (CP) appreciated the positive response with a few additional areas still to address and suggested a return visit by internal audit in three months. KT

commented that further work will include enhancements to practice, such as photographing patients' property to avoid any disputes. Ian Black (IB) asked if the Care Quality Commission (CQC) would look at this area. Sue Cordon (SC) responded that the CQC may ask staff but it would not usually be part of its checks unless it was raised as an issue. She added that photographs do not always give all the information, such as the composition of jewellery, and caution should be exercised.

AC/15/82 False or Misleading Information offence (agenda item 3.4)
Dawn Stephenson (DS) took the Committee through the paper, which was noted.

## AC/16/04 External audit plan, risk assessment and control measures (agenda item 4)

Paul Thomson (PT) introduced this item and invited Paul Hewitson (PH) to take the Committee through the detail. PH highlighted the following from the plan.

- There will be no change in materiality in 2015/16 and this will be referenced in the ISA 260 report at the year-end. The Committee agreed this was a sensible level and appropriate for the scope of the audit.
- The liaison work with internal audit through the year to develop an approach that avoids inefficiencies and overlap and in relation to clinical audit.
- In relation to the ISA 700 and the recommendation to consider whether Deloitte should include findings against each risk in the report, it was agreed that Deloitte would provide an early draft for the Committee to consider in order to come to a view.

**Action: Deloitte**

- Significant risks were identified as:
  - revenue recognition in respect of CQUIN income;
  - property revaluation;
  - Laura Mitchell House and New Street brought into use;
  - management override of controls (JC was happy that this was highlighted as a risk; however, the Trust will retain a prudent approach to its accounting practice);
  - Agresso software upgrade (due to the issues with the implementation of RiO V7, the upgrade has been deferred to June 2016. It will not, therefore, be identified as a risk in 2015/16; however, Deloitte will review the risk posed by the issues encountered during the implementation of RiO V7 and the potential impact on the Agresso upgrade).
- Three areas of potential risk were identified in relation to value for money in terms of the contractual relationships in respect of interim senior staff, the outcome of the forthcoming CQC inspection and delivery of the transformation programme. Deloitte will review the outcome of the internal audit work on the transformation programme to inform its opinion.

Jonathan Jones (JJ) asked if there was anything arising out of the Southern Health NHS Foundation Trust report to affect Deloitte's approach. PT confirmed that Deloitte was happy that its approach is right and robust and focuses on the right areas. JJ asked if the same was the case for internal audit. CP responded that the KPMG plan will focus on risk and serious incident reporting would be very much part of this. Any changes would be discussed with management and changes reflected in the plan.

In relation to Quality Accounts indicators, PH advised that Deloitte was encountering a number of difficulties and challenges with the local indicator, which are currently being discussed with the lead Director. Deloitte will advise the action it believes the Trust should take and will come back to the Committee in April 2016 to advise whether the issues have been resolved or to make a recommendation on additional work required.

**Action: Deloitte**

Deloitte is working on the assumption that the current consultation document on Quality Accounts from Monitor will become final guidance and the audit of mandatory indicators will begin in agreement with the Performance and Information Team.

PH went on to highlight the conclusions from the interim analytical procedures, which made a number of recommendations in relation to:

- a review of ledger practice to determine the reasons for the large amount of entries for such low value transactions;
- examination of the spike in corrections to ensure that the underlying root cause is understood and prevented from happening in future;
- ensuring there is a clear understanding of the functions of one particular member of staff in the finance team and that contingency plans are in place;
- exploring whether the process of coding and posting food invoices could be streamlined and automated.

JC responded that the aim is to balance the quality of information to inform decision-making without losing a robust and detailed approach. The forthcoming Finance Team time out will include a review of systems and processes.

The review timetable was noted and will include a review of the Trust's annual plan. The Committee also asked that the fees are adjusted to include this review and the well-led review.

**Action: Deloitte**

IB asked if the risk of non-payment by commissioners and others is reviewed by Deloitte as part of the audit. PH responded that Deloitte reviews evidence of post-year-end payments and seeks assurance that monies will be paid. Deloitte also scans commissioners' finance reports to see if there is any evidence of stress.

JJ commented that Trust Board has come to a view regarding additional controls in the system. He asked what other Trusts were doing in this regard. PT responded that most Trusts in financial difficulty are agreeing to the control totals set by Monitor whilst other Trusts in a similar position to this Trust are taking a more robust view; however, whatever view Trust Board takes, the Trust does need to be able to show and evidence a robust financial position.

## AC/16/05 Agreement of final accounts timetable and plans (agenda item 5)

LC commented that he would like time to review the final accounts prior to circulation to the Audit Committee. JJ asked who would sign the accounts. IB was of the view that it would be whoever the Accounting Officer is at the time and whoever occupies the position of Director of Finance. JC commented that he would be comfortable to sign the accounts as Director of Finance given his knowledge of the current position. It was agreed that JC would provide clarity as there was some uncertainty of the status of an 'interim' position and the ability to sign the accounts.

**Action: Jon Cooke**

**It was RESOLVED to APPROVE the final accounts timetable and plans.**

## AC/16/06 Review of accounting policies (agenda item 6)

**It was RESOLVED to APPROVE the changes to accounting policies.**

## AC/16/07 Audit Committee annual report (agenda item 7)

**It was RESOLVED to:**

- **APPROVE the first draft of the Committee's annual report;**
- **APPROVE the work programme for 2016; and**
- **APPROVE the changes to the terms of reference.**

The final report will be presented to the Committee along with annual reports from other risk Committees in April 2016. The changes to the terms of reference will be presented for formal approval by Trust Board in March 2016.

## AC/16/08 Decision-making framework (agenda item 8)

JC provided a verbal update. There will be no fundamental change to the Trust's standing orders at the current time. There is a concern regarding the levels of approval and escalation in relation to procurement and tendering, which appear to be low in value in comparison with other NHS organisations; however, the Trust is not an outlier in terms of the number of waivers. The conclusion is that there will not be any recommendation to change the current position as it does not cause major difficulties in terms of Trust processes. LC asked that the Committee receives a formal paper to endorse this approach in April 2016.

**Action: Jon Cooke**

## AC/16/09 Service line reporting (agenda item 9)

JC advised the Committee that development is focussing on two key areas in relation to:

- the in-year position to support BDU decision-making; and
- the strategic direction for service line reporting and how it is used.

## AC/16/10 Currency development (agenda item 10)

JC reported ongoing discussions with commissioners regarding the Trust's pricing strategy, particularly for 2016/17. Currency development nationally remains on the 'back burner'; however, the Trust continues to develop its approach.

## AC/16/11 Triangulation of risk, performance and governance (agenda item 11)

DS introduced this item. LC asked that the Executive Management Team (EMT) considers the risk posed by items on the dashboard that do not appear on the organisational risk register, in particular mandatory training and sickness absence, and whether these risks should be placed on the risk register. DS confirmed that there are robust processes through EMT to review the external and internal environment and whether there is sufficient risk posed to necessitate inclusion on the risk register and at what level. LC suggested there might be worth in an external review but appreciated that internal audit reviews and the well-led review had reviewed this area in detail.

IB asked that EMT reviews what constitutes mandatory training and considers the current blanket approach to reporting.

**Action: Alan Davis (via Dawn Stephenson)**

## AC/16/12 Treasury management update (agenda item 12)

The report was noted and **it was RESOLVED to APPROVE the changes to the policy and to the authorised signatories, subject to the following changes.** The Committee asked:

- that it is explicit that the signatory list relates to external deposits only;
- for a review of the explanation of permitted institutions; and
- for a review of the definition of a 'bank' and whether this should refer to UK domiciled institutions only.

**Action: Rob Adamson**

## AC/16/13 Internal audit progress report (agenda item 13)

Progress report

CP advised of one change to the internal audit plan in relation to 'culture' within the Trust. EMT considered the priority of this review in relation to other reviews in the plan and how it could be incorporated into the remainder of the internal audit plan for 2015/16. As a result, it was agreed that the reviews of transformation and corporate governance arrangements (as this area was subject to a robust review under the well-led framework for governance reviews during 2015) originally planned for 2015/16 are replaced by a review of 'culture' and a CQC compliance review.

Three reports were presented from the 2015/16 programme.

Payroll, which received significant assurance with minor improvement opportunities.

Information governance, which received partial assurance with improvements required. CP explained that this is a two-stage review with the second review in March 2016. She confirmed that it was not unusual for a partial assurance opinion to be given at this stage; however, there is a significant amount of work for the Trust to undertake to address the recommendations and to provide a significant assurance opinion. LC expressed a concern that the Trust reaches this position each year but accepted that staff changes had contributed to the findings.

Management of service level agreements, which received partial assurance with improvements required. CP commented that the findings are similar to those raised in the internal audit undertaken in 2013, mainly due to the effectiveness of operational delivery. She assured the Committee that there is nothing to indicate that the Trust has not received monies owed appropriately; however, the current arrangements make performance management relationships difficult. The view of the Committee was that this is an area for cost savings and provision of services in a more effective and efficient way. JC suggested that the Trust undertakes an assessment of where opportunities exist to market test in respect of services currently provided under a service level agreement. LC commented that he would like regular reports on progress against JC's suggestion.

**Action: Jon Cooke**

JJ asked whether there was a ballpark figure for cost savings from such agreements. JC responded that it was estimated as £750,000 but this is across all non-pay arrangements. By early March 2016, the Trust should be able to assess the amount for NHS to NHS organisations.

The Committee expressed its disappointment in the outcome and the timescales for the recommendations reflecting the work required to address. It did appreciate that this was not due to inertia or lack of seriousness on behalf of the Trust. JC agreed to bring a schedule to

the Committee of key milestones to address the governance issues raised as well as an assessment of opportunities to provide assurance regarding progress.

**Action: Jon Cooke**

Three draft reports were presented from the 2015/16 programme.

Financial management review, which received significant assurance with minor improvement opportunities. In response to a question from IB, CP confirmed that the response rate to the survey of budget holders was average. She agreed to discuss with the finance team to review where the responses came from and action that could be taken.

**Action: Clare Partridge**

IB commented that Trust Board has confidence in the budget setting process but is unsure of the level of involvement of budget holders and the level of 'setting' budgets by finance.

E-rostering, which received significant assurance with minor improvement opportunities. The recommendations will help inform a review of strategic workforce management and policy, which forms part of the internal audit plan in 2016/17. CP confirmed that the scope of the audit covered ward-based staff. Chris Jones (CJ) asked if there was an opportunity to roll-out e-rostering across all Trust staff and IB suggested that the Trust looks at opportunities for extending this to all staff.

Job planning, which received partial assurance with improvements required. SC took the Committee through the findings. The Committee understood that the recommendations and management response have still to be agreed with the Medical Director. The final report will be presented to the Committee at the next meeting. The Committee asked about any cost saving assumptions and noted that these were more in relation to consistency of arrangements across the Trust rather than from job planning itself.

Other items

In terms of the Head of Internal Audit Opinion, CP commented that there were a number of concerns regarding the outcomes of risk-based audits; however, the outcome of audit of core processes has been positive and these form the basis of the Opinion. JJ asked about themes and CP responded that there may be some coming through which could be a cause for concern.

The Committee noted that the CQC compliance review has begun and will include an in-depth look at risk assessment and care planning. The review will result in a number of recommendations the Trust can implement prior to its inspection.

LC commented on the deterioration in the performance measure relating to 'management response received within fifteen days'. CP responded that the complexity of recommendations arising from certain audits has required co-ordination from a number of staff across the Trust delaying the management response.

Follow up report

The report was noted. The Committee asked that the outstanding recommendations relating to the 2015/16 performance indicators (mental health data completeness) are escalated to Director-level and, if necessary, a report provided to the Committee prior to the next meeting with an update at the next meeting.

**Action: Jon Cooke**

Technical update

The technical update was noted.

## AC/16/14 Counter fraud (agenda item 14)

Counter fraud progress report (agenda item 14.1)

Jon Cohen (JCo) took the Committee through the report and the update on the counter fraud referral was noted. This will result in KPMG exceeding its resource allocation and JCo will discuss with JC to ensure resource is in place. He will ensure Deloitte is informed of the Trust's exposure.

**Action: KPMG**

JCo also advised of a second referral received although it is not clear at this stage whether there has been any wrongdoing by the individual concerned.

Standards for Providers self-review toolkit (January 2016) (agenda item 14.2)

The Committee noted that an 'amber' rating represents compliance and is the current position of the Trust ('amber' overall). Progress against the action plan will be presented to the Committee on an ongoing basis. JC commented that it would be helpful for there to be a consistent definition of what 'amber' means.

*Jonathan Jones left the meeting at this point.*

Fraud and corruption policy (agenda item 14.3)

CJ suggested that the policy should reflect a more local approach, which JCo agreed to draft for inclusion in the policy.

**Action: KPMG**

## AC/16/15 Procurement report (agenda item 15)

Tony Cooper (TC) took the Committee through his report. He reported that use of temporary staff has increased this quarter; however, the Trust remains fully compliant in using national framework suppliers. There will be an impact as a result of the reduction in agency rates and a briefing note for BDUs has been developed on agency staffing.

IB asked if the Committee could receive a trend analysis by value and number for single source tenders.

**Action: Tony Cooper**

## AC/16/16 Losses and special payments report (agenda item 16)

The report was noted.

## AC/16/17 Items to report to Trust Board (agenda item 17)

These were agreed as:

- internal audit reports and the issues raised in relation to patient's property, service line agreements and job planning (although it was again noted that the final report had not yet been agreed with management);
- external audit plan and timetable; and
- Quality Accounts local indicator.

## AC/16/18 Date of next meeting (agenda item 18)

The next meeting will be held on Tuesday 5 April 2016 at 14:00 in the Boardroom, Kendray, Barnsley.

## AC/16/19 Any other business (agenda item 19)

IB suggested that, following the first prosecution for corporate manslaughter, the Trust undertakes a risk assessment and provides a report to the Committee.

**Action: Jon Cooke to take forward with EMT colleagues**

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South West Yorkshire Partnership NHS
NHS Foundation Trust

# Minutes of Clinical Governance and Clinical Safety Committee held on 23 February 2016

| | | |
|---|---|---|
| **Present:** | Charlotte Dyson | Non-Executive Director |
| | Julie Fox | Deputy Chair of the Trust (Chair) |
| | Adrian Berry | Medical Director |
| | Tim Breedon | Director of Nursing, Clinical Governance and Safety |
| | Alan Davis | Director of Human Resources and Workforce Development |
| | Dawn Stephenson | Director of Corporate Development |
| **Apologies:** | Ian Black | Chair of the Trust |
| **In attendance:** | Nette Carder | Interim BDU Director, CAMHS and forensic services |
| | Bernie Cherriman-Sykes | Integrated Governance Manager (author) |
| | Mike Doyle | Deputy Director, Nursing, Clinical Governance and Safety |
| | Dave Ramsay | Deputy Director Operations (for item 10) |
| | Sean Rayner | District Director, Barnsley and Wakefield |
| | Diane Smith | Director of Health Intelligence and Innovation |
| | Karen Taylor | District Director, Calderdale and Kirklees |

## CG/16/01 Welcome, introduction and apologies (agenda item 1)

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

## CG/16/02 Minutes of the previous meeting held on 2 November 2015 (agenda item 2)

**It was RESOLVED to APPROVE the minutes of the meeting held on 2 November 2015.**

## CG/16/03 Matters arising (agenda item 3)

There were three matters arising.

CG/15/83 Creating a smoke-free environment (agenda item 3.1)

Adrian Berry (ABe) advised that implementation had gone well and there will be an evaluation at the six-month point. The review will look particularly at whether there is any need to review the policy in place and will also assess whether a revised approach is needed in respect of the use of vapours.

CG/15/89 Nurse re-validation (agenda item 3.2)

Tim Breedon (TB) advised that the nurse re-validation policy sets out the arrangements if a member of staff is not re-validated, which is the same as a lapse in registration.

CG/15/90 Update on exceptional case at Newton Lodge (agenda item 3.3)

ABe updated the Committee that a potential placement has been identified but is unlikely to be available until the summer; however, he was not particularly confident that the placement would happen.

## CG/16/04 Committee annual report, review of terms of reference and approval of annual work plan (agenda item 4)

Annual report

It was agreed to add the review of the implications of the report on Southern Health NHS Foundation Trust and patient-led assessments of the care environment (PLACE) (under 3.4) and to refer to the establishment of the Equality and Inclusion Forum and agreement of its priorities (under 3.3).

Terms of reference

The membership will be amended prior to presentation to the Audit Committee and it was agreed to add District Directors in attendance at meetings.

Work programme

It was agreed to add learning lessons report in February and September, independent review (Horizon) in February 2016, national audit on schizophrenia action plan and mandatory training annual report to June's meeting.

**It was RESOLVED to APPROVE the first draft of the Committee's annual report, APPROVE changes to the work programme for 2016 and APPROVE the changes to the terms of reference.**

**Action: Dawn Stephenson**

## CG/16/05 Transformation – exception report (agenda item 5)

TB advised that there were no significant risks emerging to report to the Committee that might impact on clinical safety. The high level summary report produced for the Executive Management Team (EMT) will be brought into the Committee in future. Karen Taylor (KT) advised that, from a service perspective, transformation remains a challenge but the Trust is beginning to see some movement and progress. Sean Rayner (SR) added that the continuing challenge is alignment of transformation of Trust services with that of partners and stakeholders. Nette Carder (NC) commented that transformation of learning disability services is at a critical stage but in a positive way and a shift to mainstream delivery is imminent. It was agreed to receive a summary of the conclusion of the project when the project board is dissolved.

**Action: Nette Carder**

*NB where action has been assigned to Nette Carder, this will transfer to, and be picked up by, Carol Harris, Director of forensic and specialist services.*

## CG/16/06 Independent review of safeguarding arrangements (agenda item 6)

The report was noted.

## CG/16/07 Learning lessons from incidents (agenda item 7)

The report was noted. The next report will come to the meeting in September 2016.

**Action: Tim Breedon**

## CG/16/08 Suicide prevention strategy (agenda item 8)

Mike Doyle (MD) introduced this item. Charlotte Dyson (CD) commented that she did not think that links to a multi-agency approach were articulated strongly enough in the strategy. JF commented that she would like to see collaboration and partnership much more prominently in the strategy and for educational establishments to be added to the list of stakeholders.

MD highlighted the strong link with the Urgent and Emergency Care Vanguard in West Yorkshire and suicide prevention was discussed at a conference on 8 February 2016 (see agenda item 19.1) focussing on the production of a multi-agency strategy for West Yorkshire with an aim to reduce suicide overall. Diane Smith (DCS) commented that there will be a series of workshops to support the Vanguard with an assessment of what can be done and at what level.

MD was also asked to include reference to eating disorders.

**Action: Mike Doyle**

## CG/16/09 Quality Accounts 2015/16 (agenda item 9)

An updated version of the Quality Accounts dashboard was tabled. TB commented that there would be some value of a further discussion on commissioning for quality and innovation (CQUIN) payments and how these are constructed and it was agreed to receive a paper in June 2016.

**Action: Sean Rayner/Karen Taylor**

MD commented that he was confident the Trust would achieve the Quality Accounts measures at the year-end but raised two areas to note.

- Care planning – the reliability of the measure is of concern and this is to be reviewed both for the remainder of the year and for 2016/17.
- Friends and family test – child and adolescent mental health services figures skew the total given the activity to encourage people to complete the test in Calderdale and Kirklees.

JF commented that, under Priority 3, monitoring the quality of care plans, it was unclear what the figure of 49% applies to. Whilst appreciating that this is a high level report, she would like to see the detail.

**Action: Mike Doyle**

Alan Davis (AGD) commented that it is clear what the staff friends and family test is benchmarked against and, therefore, where the Trust sits for both a place to work and for care and treatment.

The Committee noted that the recommendations made by Deloitte following the audit of the Quality Accounts in May 2015 have been completed.

## CG/16/10 Child and adolescent mental health services (CAMHS) (agenda item 10)

NC took the Committee through the report. She highlighted the additional funding and investment under Future in Mind and for services such as eating disorders. In response to a question from JF, she advised that the differences in Autism Spectrum Disorder service in Calderdale and Kirklees, and in Barnsley reflects the different approaches to addressing waiting list issues by commissioners. JF suggested contact with headteachers in Barnsley and SR responded that in terms of perception and reputation, this is an area of concern for the Trust in Barnsley.

Dawn Stephenson (DS) will discuss the friends and family test with Dave Ramsay (DR) to feed into the paper for the Committee in April 2016 (commissioned by Trust Board).

NC commented that the Trust has commissioned an independent review of information governance incidents in relation to administrative processes in Calderdale and Kirklees.

MD commented on the review of looked-after children in Wakefield. The outcome was positive and complimentary in terms of the Trust's CAMHS provision in Wakefield.

JF asked for trend analysis for the performance information contained in the report (appendix 1). DCS will discuss with NC how to best present the analysis for future reports.

**Action: Diane Smith/Nette Carder**

## CG/16/11 Barnsley Healthy Child Programme and Family Nurse Partnership update (agenda item 11)

TB reported that the Trust continues to work with Barnsley Council to come to an agreement of what can be delivered safely within the financial envelop available. By the end of this week, preliminary work should be completed with an assessment of the risk and implications ready for the report to Trust Board on 29 March 2016.

## CG/16/12 Horizon review (agenda item 12)

NC took the Committee through the report. Further reports will come to the Committee in six and twelve months.

**Action: Nette Carder**

The report demonstrates the progress that has been made although much work remains, particularly to develop multi-disciplinary team arrangements. Robust management of the action plan will continue.

NC extended an invitation to Trust Board to visit Horizon and suggested the end of March 2016.

NC also updated the Committee on the situation with the challenging individual currently on the Horizon Centre and the implications for the delivery of services. It very much impacts on the responsiveness and accessibility both for service users on the unit and for assessment and treatment of other service users.

## CG/16/13 Implementation of twelve-hour shifts (agenda item 13)

MD provided a brief update to the Committee prior to a full report to April's meeting.

**Action: Mike Doyle**

Headlines to date were reported as follows.

- Use of bank staff has reduced and agency increased, but not as a result of the introduction of twelve-hour shifts.
- The take-up of mandatory training has improved.
- Stack and fill rates have increased.
- Break times missed have reduced.
- There has been no real change in sickness absence.
- Turnover has increased across the Trust but by not as much in areas where twelve-hour shifts have been introduced.
- Issues remain with communications and supervision but these are being addressed.
- Mixed views remain amongst staff but the move has been generally welcomed by service users.

## CG/16/14 Emergency planning review of IT virus incident (agenda item 14)

AGD explained that the paper sets out the key lessons from the review of business continuity arrangements in the event of an incident such as the IT virus. The annual health and safety report will include the outcome of the testing of business continuity systems and demonstrate how the Trust has learned lessons.

**Action: Alan Davis**

In response to an issue raised by JF, AGD confirmed that much work has been done on the Trust's main sites to develop appropriate lockdown procedures and communicate these to staff.

## CG/16/15 Quality impact assessment of cost improvement programme (agenda item 15)

The update was noted. The process will undoubtedly become more challenging and rigorous as savings become more challenging to identify, become increasingly more transformational in nature, and as, through the year, mitigations and substitutions are put forward. The process will also apply to cost pressures.

JF asked if there was any evidence that transformation will support the cost savings programme. TB responded that, in reality, the savings focus on the benefits of improved productivity and changes to practice; it is likely to be the longer-term before savings materialise from transformation itself.

## CG/16/16 Improving access to psychological therapies (agenda item 16)

KT took the Committee through the report, which was noted.

## CG/16/17 Implications arising from the report on Southern Health NHS Foundation Trust (agenda item 17)

The report was received by Trust Board on 29 January 2016 and the Members' Council on 12 February 2026, and noted by the Committee.

## CG/16/18 Care Quality Commission (agenda item 18)

Care Quality Commission – preparation for the inspection visit (agenda item 18.1)

TB provided an update for the Committee.

- The factual accuracy check is complete.
- The performance related data will be refreshed by the end of this week.
- Dates and details of the visit programme are beginning to come through.
- The team will be based in the Learning and Development Centre at Fieldhead, Wakefield, from early March 2016.

Care Quality Commission Mental Health Act visits – clinical and environmental (agenda item 18.2)

Clinical issues

The Committee noted the good progress made. JF commented that she would like to see evidence that information has been disseminated to staff, for example, otherwise the Committee cannot really be assured that action has taken place. She would not want recommendations to turn to 'green' until progress is demonstrated. She asked that this is resolved prior to the Mental Health Act on 2 March 2016. TB suggested a review by district directors; however, it was agreed that this was not realistic within the timescales and the

outcome of a full review would be presented to the Committee in April 2016. SR confirmed that action should not be 'signed off' until evidence of action is received.

**Action: Nette Carder/Sean Rayner/Karen Taylor**

Environmental issues
AGD advised that many actions had been updated at the Estates TAG meeting held on 19 February 2016. These will be reflected in the next report.

JF clarified that the decision to remove an action from the report rests with the Mental Health Act Committee. This includes resolution of long-term issues where there is no benefit to retain a recommendation on the report indefinitely.

## CG/16/19 Incident management (agenda item 19)

Incident management report Q3 2015/16 (agenda item 19.1)
MD took the Committee through the highlights of the report, which was appreciated and welcomed by the Committee.

Undetermined deaths report (agenda item 19.2)
The Committee noted the report and commented that it found it very helpful and well presented.

## CG/16/20 Sub-groups – exception reporting (agenda item 20)

Drugs and therapeutics (agenda item 20.1)
The report was noted.

Health and safety (agenda item 20.2)
AGD reported there were no issues to raise.

Infection Prevention and Control (agenda item 20.3)
The Committee noted the review of requirements under the Health and Social Care Act guidance and development of an associated action plan.

Safeguarding (agenda item 20.4)
The report was noted.

Managing aggression and violence (agenda item 20.5)
JF asked if the Trust could look at recording the length of time a service user is subject to prone restraint. TB agreed to review in terms of improving the quality of information provided and how this could be recorded on DATIX.

**Action: Tim Breedon**

Any feedback from other TAGs/groups (agenda item 20.6)
TB updated the Committee on the current position following the implementation of RiO V7. A stocktake of the position highlights five key areas:

- access to RiO via smartcard;
- slow performance;
- 'dropping out';
- access to forms introduced with V7; and
- work not saving.

A further review will be undertaken to assess the position on 7 March 2016 when the CQC begins its inspection and how the Trust and staff will manage access to the system. The

issues with RiO are also having an impact on the quality of information recorded by staff. The position continues to represent a clinical risk to the Trust although staff are continuing to show resilience in working with the system. AGD added that it is important for the Committee to be assured that patient safety and clinical risk are managed through mitigating action in place.

Connectivity and interoperability of the system will also be assessed prior to the CQC visit.

**CG/16/21 Issues and items to bring to the attention of Trust Board (agenda item 21)**

Issues were identified as:

- suicide prevention strategy;
- CAMHS;
- RiO V7 implementation;
- Mental Health Act visits;
- improving access to psychological therapies; and
- quality impact assessment of cost improvement programme.

**CG/16/22 Date of next meeting (agenda item 22)**

The next Committee meeting will be held on Monday 18 April 2016 at 14:00 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

# Minutes of the Remuneration and Terms of Service Committee held on 9 February 2016

| | | |
|---|---|---|
| **Present:** | Ian Black | Chair of the Trust (Chair) |
| | Rachel Court | Non-Executive Director |
| | Jonathan Jones | Non-Executive Director |
| **Apologies:** | Steven Michael | Chief Executive |
| **In attendance:** | Laurence Campbell | Non-Executive Director |
| | Alan Davis | Director of Human Resources and Workforce Development |
| | Bernie Cherriman-Sykes | Integrated Governance Manager |

## RTSC/16/01 Welcome, introduction and apologies (agenda item 1)

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

## RTSC/16/02 Minutes of the previous meeting held on 17 November 2015 (agenda item 2)

**It was RESOLVED to APPROVE the minutes from the previous meeting held on 17 November 2015.**

## RTSC/16/03 Matters arising from the meeting held on 17 November 2015 (agenda item 3)

RTSC/15/58 Changes to pension arrangements

*The Committee noted the interest declared by Rachel Court in relation to her role as Chair of the NHS Pensions Board.*

Alan Davis (AGD) reported that the changes to pension arrangements will have an impact on the Trust as a cost pressure of £3.5 million. The changes will also have an impact on individuals, particularly senior staff, medical staff and clinicians, which will affect individual career decisions. The pension changes coupled with the changes to National Insurance will have a different impact for individuals depending on age, length of service, etc.

AGD added that it is evident that there is a growing concern at the cost of the pension scheme to individuals and staff are not joining or are opting out. There will be further communications to promote the benefits to both new and existing staff.

AGD was asked to bring statistical information on pensions within the Trust to the next meeting.

**Action: Alan Davis**

IB asked if this issue needed to be escalated to the organisational risk register given the potential impact on staff and the Trust and it was agreed this should be discussed further by the Executive Management Team (EMT).

**Action: Alan Davis**

Rachel Court (RC) asked if the Trust offers a cash alternative to those who opt out of the pension scheme. AGD responded that it is not something the Trust would consider. The benefit to the Trust and to the staff member is already realised by not having to pay contributions.

Jonathan Jones (JJ) asked about succession planning in place at Board level. AGD responded that deputy directors are in place for all Directors and this is a key objective of the Leadership and Management Development Strategy (agenda item 8). He added that the age profile of medical staff is also of concern.

## RTSC/16/04 HR exception report (agenda item 4)

Sickness absence

The Committee received a detailed report on sickness absence. AGD commented that a range of actions are in place to address current sickness levels, including health coaching, inclusion in Directors' and trios' objectives, and revision of the staff absence policy to ensure consistency across the Trust. Stress remains the biggest cause of absence. Current payment arrangements for absence are part of national Agenda for Change arrangements; however, there may come a point where the Trust is unable to continue to afford these arrangements and a move to develop local contracts and terms and conditions may be considered.

IB invited comments from the Committee.

- Laurence Campbell (LC) asked if there is intelligence as to whether staff on long-term sickness absence are working elsewhere. AGD responded that there are occasions the Trust is aware of and these are pursued through disciplinary and legal channels. There is also triangulation nationally through National Insurance numbers.
- JJ asked what action the Trust is taking in relation to sickness absence rates. AGD responded that the Trust will target the top 200 through a wellbeing and engagement process and focus on areas, such as forensic services, to provide targeted support for managers to reduce absence through health coaching and performance management of their management of individual members of staff as part of a wider performance dashboard for trios within BDUs.
- RC asked whether individuals were given 'targets' through the process that sets trigger points for further action. AGD responded that standards are set for attendance once individuals are in the process.
- IB commented that he would like to see individual Director objectives within the performance related (PRP) scheme to reflect the concern the Committee has in relation to sickness absence in their directorates/BDUs.
- AGD confirmed that an assumption in relation to sickness absence is made in the budget of 4% but this only relates to in-patient areas where replacement staff may be needed to cover absence.
- AGD also commented that increasing the sickness absence target has had unforeseen consequences. The lower target provided a focus and was at an aspirational level. The increase has acted as a disincentive to the continued drive to reduce absence. The Committee was supportive of a return to a target of 4% in 2016/17.
- JJ asked that the Committee receives a full report on a quarterly basis and AGD suggested that, for areas of concern to the Committee, the lead Director is invited to attend to explain the position and action to address. The reports will also include a focus on a particular area, such forensics.

**Action: Alan Davis**

## RTSC/16/05 Clinical Excellence Awards (agenda item 5)

AGD outlined the changes to the scheme to ensure individuals receiving awards do so for activity over and above their role and in support of the Trust's objectives, including clinical leadership. The Panel was also strengthened to ensure a balance of clinical and non-clinical representation. He confirmed that successful applications are public and included on the

Trust's intranet. JJ commented that he would like to see a stronger correlation between exceptional performance and the awards made.

**It was RESOLVED to RATIFY the Clinical Excellence Awards approved by the Panel.**

For future years, IB asked AGD to consider utilising Charlotte Dyson's skills and experience as a Lay Assessor for Clinical Excellence Awards and to also consider whether she should sit on the Awards Panel.

**Action: Alan Davis**

## RTSC/16/06 Appointment of Executive Directors/Chief Executive (agenda item 6)

Chief Executive appointment

IB informed the Committee that there was an original shortlist of three candidates to interview on 10 and 11 February 2016; however, one candidate withdrew on 5 February 2016. IB and AGD considered the Trust's position and it was agreed to go ahead with two candidates. IB outlined his reservations but felt the right option was to continue with the process. RC asked if there were any other candidates on the longlist worth considering. IB responded that six others were put through the process but nothing identified they were of the quality of the two final candidates

Director of Finance

IB updated that a longlist of candidates is currently with Harvey Nash for further assessment. All are existing Directors of Finance, which represents a very strong field. The new Chief Executive will be fully involved in the shortlisting process and will Chair the interview panel.

Director of Forensic and Specialist Services

Carol Harris will take up appointment on 21 March 2016. Carol is currently Acting Director of Operations at Manchester Mental Health and Social Care NHS Trust. Nette Carder will remain with the Trust until 25 March 2016.

## RTSC/16/07 Directors' performance related pay scheme 2015/16 (agenda item 7)

AGD updated on behalf of the Chief Executive (SM). Directors' quarter 3 reviews are complete with the outcome and next steps confirmed with Directors. This included an updated fit and proper persons test assessment. Quarter 4 reviews will be completed before SM leaves on 31 March 2016. This will include input from Non-Executive Directors. Another meeting of the Committee will, therefore, be needed before the end of March 2016. One of the gateway targets is tied to the outcome of the Care Quality Commission (CQC) inspection; therefore, the final outcome will not be known until May or June 2016. The Committee was reminded that there will be no payment unless all gateway targets are achieved, which includes at least a 'good' CQC rating.

IB asked about the process for setting Directors' objectives for 2016/17. AGD responded that these would normally come to the Committee's meeting in April and he will agree a process and timetable with SM.

**Action: Alan Davis**

## RTSC/16/08 Leadership and management development strategy (agenda item 8)

AGD took the Committee through the headlines emerging from 'year 1' delivery, developments and the plan for 2016/17.

## RTSC/16/09 Business cases for redundancy (agenda item 9)

**It was RESOLVED to APPROVE the business cases for redundancy.**

LC asked for an update on progress of the review of management administration costs. AGD responded that the scoping exercise is complete and is with managers and Directors to confirm. Some aspects may be covered by existing cost improvement proposals and care will, therefore, be needed to ensure there is no double counting. The process will inform the budget for 2016/17 presented to Trust Board on 29 March 2016.

## RTSC/16/10 NHS Providers remuneration survey results (agenda item 10)

The survey results were noted. RC asked if the remuneration offered for the Chief Executive's appointment was sufficient to attract the candidates selected for interview. IB responded that there is guidance for Very Senior Managers' pay and it is the Trust's intention, and this has been communicated to the regulator, to recruit within the current Chief Executive's pay package.

## RTSC/16/11 Review of Remuneration and Terms of Service Committee (annual report) (agenda item 11)

**It was RESOLVED to APPROVE the first draft of the Committee's annual report.**

Subject to the addition of sickness absence as a standing item on the Committee's agenda, **it was RESOLVED to APPROVE the work programme for 2016.**

With regard to the terms of reference, LC suggested including an obligation to consider risk within the scope of the Committee's remit. Subject to this inclusion, **it was RESOLVED to APPROVE the current terms of reference.**

## RTSC/16/12 Any other business (agenda item 12)

Shadow Board

AGD informed the Committee of a programme, fully funded by the NHS Leadership Academy and run by Finegreen (a recruitment and development agency) and Inspiring Leaders Network (an organisation providing learning opportunities across health and social care), that would put twelve staff through learning modules with a view to create a shadow board chaired by a Non-Executive Director, which would consider public session papers. A detailed proposal will be presented to the next meeting.

**Action: Alan Davis**

## RTSC/16/13 Date of next meeting (agenda item 13)

As agreed there will be an additional meeting before the end of March 2016 to consider Directors' performance related pay 2015/16 and Directors' objectives for 2016/17. *[This meeting will be held on Tuesday 22 March 2016 at 10:30 in the Chair's office at Fieldhead.]* The next scheduled meeting will be held on Tuesday 12 April 2016 at 10:00 in the Chair's office, Block 7, Fieldhead, Wakefield.

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# Trust Board 29 March 2016
# Agenda item 4.7

| | |
|---|---|
| **Title:** | **Proposed changes to Trust Board Committee terms of reference** |
| **Paper prepared by:** | Director of Corporate Development on behalf of Committee Chairs |
| **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. Clear terms of reference for Trust Board Committees, which set out their role and remit and are reviewed annually, support the Trust's values of openness and transparency. |
| **Any background papers/ previously considered by:** | Committee terms of reference have been reviewed by each Committee as part of development of their annual reports to the Audit Committee, which will be presented to Trust Board on 29 April 2016. |
| **Executive summary:** | As part of the Audit Committee's responsibilities, it undertakes an annual review of Trust Board Committees' effectiveness in terms of their role and responsibilities set out in their terms of reference. Each Committee produces an annual report and, as part of this process, reviews its terms of reference and work programme. The following changes are proposed in relation to Committee terms of reference.<br><br><u>Audit Committee</u><br>In January 2015 at the request of the Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. There were a number of minor points of best practice in relation to the Committee terms of reference, which related to:<br><br>1. a stronger narrative around scrutiny of the effectiveness of control arrangements and arrangements for staff to confidentially raise concerns;<br>2. a statement on the responsibility to develop and implement a policy on the provision of non-audit services and<br>3. clarification of the Committee's role and relationship with the Members' Council, as articulated in Monitor's Code of Governance.<br><br>The changes were approved by Trust Board in September 2015 and were incorporated in the Committee's terms of reference, which were considered and approved at its meeting on 2 February 2016.<br><br><u>Clinical Governance and Clinical Safety Committee</u><br>The only change proposed and supported was the addition of District Directors as in attendance at meetings. (See also below under Mental Health Act Committee.)<br><br><u>Mental Health Act Committee</u><br>The Committee proposed that, under duties, reference is made to measuring the impact and evaluation of the Committee's work, particularly in terms of |

| | |
|---|---|
| | demonstrating where the Committee has raised issues and where this has improved performance or changed practice. This was supported and it was suggested that this should also be added to the terms of reference for the Clinical Governance and Clinical Safety Committee.<br><br><u>Remuneration and Terms of Service Committee</u><br>The Committee approved a suggestion from the Chair of the Audit Committee to include an obligation to consider risk within the scope of the Committee's remit. |
| **Recommendation:** | **Trust Board is asked to APPROVE the proposed changes to Committee terms of reference as set out above.** |
| **Private session:** | Not applicable |

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# Trust Board 29 March 2016
# Agenda item 6

| | |
|---|---|
| **Title:** | **Finance plan and budget summary 2016/17** |
| **Paper prepared by:** | Interim Director of Finance |
| **Purpose:** | For Trust Board to approve the annual budget for 2016/17 in advance of the submission of the Annual Plan to Monitor on 11 April 2016. |
| **Mission/values:** | The annual planning and budget underpin the use of resources in all services to meet the mission and values of the Trust. |
| **Any background papers/ previously considered by:** | The draft operational plan was considered by Trust Board at the meeting held on 29 January 2016 and the updated draft plan and budget was reviewed by Trust Board at a workshop on 22 March 2016. |
| **Executive summary:** | **Key points**<br>• Trust Board oversees the annual planning and budget process each year with the approval of the annual budget in March each year.<br>• In addition, the exercise is also designed to meet regulatory requirements for planning. For 2016/17, two submissions are required by Monitor – a one year operational plan on 11 April 2016 and a five year joint Strategic Transformation Plan submitted jointly by commissioners and providers on 30 June 2016.<br>• The annual plan has retained the key principles agreed by Trust Board as described below.<br>➢ A recurrent underlying surplus which is increased non-recurrently to fund the capital programme.<br>➢ Continued significant capital investment in 2016/17 funded through use of existing Trust cash balances.<br>➢ Prioritising capital expenditure which will enable service redesign, reduce estate costs or generate income through increased service offer.<br>➢ A Financial Risk Rating of 3 or above on the Continued of Service Risk rating.<br>➢ Demonstrate efficiency of at least 3.5% through the Quality & Efficiency (CIP) savings programme;<br>The key headlines in the 2016/17 budget are as follows.<br>• An increase in healthcare income of £1.4 million due to the inflationary increase to the national tariff.<br>• Delivery of £10.1 million CIP programme in year which represents 4.7% efficiency.<br>• Pay expenditure uplift consistent with national guidance.<br>• Additional £4.4 million investment in services, which is split £3.0 million recurrent and £1.4 million non-recurrent.<br>The key elements of cost pressures of £6.8 million:<br>• safer wards and staffing investment £0.8 million<br>• clinical staffing £0.7 million |

| | |
|---|---|
| | • Quality Academy staffing £0.6 million<br>• estates strategy £0.6 million<br><br>The current budget plan reflects the income assumptions as currently understood. The income position remains at risk even though the Trust operates on a block contract as it is possible that acute provider positions will deteriorate and commissioners will be seeking remedial action from across their contracts to maintain their financial position.<br><br>The overall position is an underlying recurrent surplus of £1.12 million with an in-year reported surplus of £500,000.<br><br>The cash position remains healthy and is supporting a proposed £16 million capital programme in 2016/17.<br><br>The overall Monitor financial risk rating for the plan is 4 out of 4. |
| **Recommendation:** | **Trust Board is asked to:**<br>• **APPROVE the Annual Budget for 2016/17 outlined in this paper;**<br>• **APPROVE the annual budget for the final submission to Monitor on 7 April 2016 with delegated authority to Chair and Chief Executive to authorise any changes in the interim between 29 March 2016 and the submission date.** |
| **Public session:** | Not applicable |

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**SWYPFT Annual Plan 2016/17** **Appendix 1**

| Monitor Financial Risk Ratings | | | | |
|---|---|---|---|---|
| | Forecast 2015/16 | | 2016/17 Plan | |
| **Metric** | | Rating | | Rating |
| Capital Service Capacity | | 4 | | 4 |
| Liquidity | | 4 | | 4 |
| I & E Margin | | 3 | | 3 |
| I & E Margin from Plan | | 3 | | 3 |
| **Weighted Average** | | 4 | | 4 |

| Key Financial Metrics | | | | |
|---|---|---|---|---|
| | Forecast 2015/16 | | 2016/17 Plan | |
| EBITDA | 6,482 | 2.9% | 8,980 | 4.0% |
| Surplus / (Deficit) | 100 | 0.04% | 500 | 0.2% |
| Surplus - Recurrent | | | 1,120 | 0.5% |
| CIP | 8,248 | 3.74% | 10,059 | 4.7% |
| Cost Pressures | | | 4,403 | 2.0% |
| Capital | 11,500 | | 12,313 | |

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**SWYPFT Annual Plan 2016/17**

**Appendix 2**

## Annual Plan Position 2016/2017

| | 15/16 FOT | 2016 / 2017 | | |
|---|---|---|---|---|
| | Total | Rec | Non Rec | Total |
| Healthcare Income | 209,810 | 211,241 | 0 | 211,241 |
| Other Income | 16,917 | 13,397 | 0 | 13,397 |
| Total Income | **226,727** | **224,638** | **0** | **224,638** |
| | | | | |
| Pay | (170,958) | (172,629) | (431) | (173,060) |
| Non Pay | (49,287) | (42,819) | 221 | (42,598) |
| Total Expenditure | **(220,245)** | **(215,448)** | **(210)** | **(215,658)** |
| EBITDA | 6,482 | 9,190 | (210) | 8,980 |
| | | | | |
| Capital Charges - Depreciation & PDC | (9,440) | (8,555) | 0 | (8,555) |
| Interest | 76 | 75 | 0 | 75 |
| Estates Impairment | | 0 | 0 | 0 |
| Estates Revaluation | 2,981 | 0 | 0 | 0 |
| Restructuring & Re-organisation | | | | 0 |
| **Surplus / (Deficit)** | **100** | **710** | **(210)** | **500** |

| | | |
|---|---|---|
| **EBITDA as percentage of Operating Expenditure** | **2.9%** | **4.2%** |
| **Surplus as percentage of Income** | **0.0%** | **0.2%** |

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NHS Foundation Trust

# Quality Performance Report

## Strategic Overview

February 2016

# Table of Contents

# Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for February 2016 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

# Strategic Overview Dashboard

## Business Strategic Performance Impact & Delivery

| 1 | Section | KPI | Source | Target | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Q1 | Q2 | Q3 | National Average | 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 | | 4 |
| 3 | | Monitor Finance Risk Rating (FT) | M | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | | 4 |
| 4 | CQC | CQC Quality Regulations (compliance breach) | CQC | 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* | | 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 | | 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 | | 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 | | 3 |
| 9 | | CQUIN Forensic | C | Green | Amber/G | Amber/G | Amber/G | Amber/G | Amber/G | *Green* | Amber/G | Amber/G | *Amber/G* | Amber/G | *Amber/G* | Amber/G | *Green* | *Amber/G* | | 3 |
| 10 | Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | C | 6 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | | 4 |
| 11 | C-Diff | C Diff avoidable cases | C | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 4 |
| 12 | Outcomes | % SU on CPA in Employment | L | 10% | 6.55% | 7.34% | 7.18% | 6.97% | 7.38% | 7.55% | 7.68% | 7.32% | 7.37% | 7.17% | 7.25% | 7.18% | 7.55% | 7.37% | | |
| 13 | | % SU on CPA in Settled Accommodation | L | 60% | 60.27% | 65.26% | 64.44% | 57.79% | 60.34% | 62.81% | 64.46% | 63.39% | 64.09% | 63.56% | 62.26% | 64.44% | 62.81% | 64.09% | | |

## Customer Focus

| 14 | Section | KPI | Source | Target | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Q1 | Q2 | Q3 | National Average | Year End Forecast Position |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Complaints | % Complaints with Staff Attitude as an Issue | L | < 25% | 12% 8/66 | 14% 6/44 | 13% 9/69 | 12% 9/73 | 12% 5/42 | 15% 6/41 | 12% 5/42 | 16% 9/58 | 15% 6/40 | 7% 4/57 | 13% 10/74 | 14% 23/179 | 13% 20/156 | | | 4 |
| 16 | Service User Experience | Friends and Family Test | L | TBC | 89.00% | 92.00% | 87.00% | 93.00% | 89.00% | 91.00% | 88.00% | 85.79% | 93.51% | 89% | 88.00% | 89.00% | 91.00% | 88.83% | | |
| 17 | MAV | Physical Violence - Against Patient by Patient | L | 14-20 | Above ER | Above ER | Above ER | Within ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | | 4 |
| 18 | | Physical Violence - Against Staff by Patient | L | 50-64 | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | Above ER | | 4 |
| 19 | FOI | % of Requests for Information Under the Act Processed in 20 Working Days | L | 100% | 100% 24/24 | 100% 17/17 | 100% 24/24 | 100% 28/28 | 100% 20/20 | 100% 25/25 | 100% 19/19 | 100% 13/13 | 100% 19/19 | 100% 23/23 | 100% 23 requests | 100% 65/65 | 100%73/73 | 100% (51/51) | | 4 |
| 20 | Media | % of Positive Media Coverage Relating to the Trust and its Services | L | 60% | 92.00% | 92.00% | 92.00% | 80.00% | 75.00% | 50.00% | 40.00% | 50.00% | Data avail month end | Data avail month end | Data avail month end | 92.00% | 68.00% | | | 4 |
| 21 | Befriending services | % of Service users allocated a befriender or volunteer led group support (gardening/music/social) within 16 weeks | L | 70% | 50.00% | 50.00% | 50.00% | 20.00% | 20.00% | 100% | 100% | 100% | 100% | 100% | 100% | 50.00% | 20.00% | 100% | | 4 |
| 22 | | % of Service Users Requesting a Befriender Assessed Within 20 Working Days | L | 80% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | 4 |
| 23 | | % 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% | | 4 |

## Operational Effectiveness: Process Effectiveness

| 24 | Section | KPI | Source | Target | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Q1 | Q2 | Q3 | National Average | Year End Forecast Position |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | Monitor Risk Assessment Framework | Max time of 18 weeks from point of referral to treatment - non-admitted | M | 95% | 99.11% | 100% | 99.86% | 100% | 99.32% | 98.60% | 99.86% | 97.64% | 100% | 97.91% | 99.18% | 99.70% | 99.28% | 99.18% | | 4 |
| 26 | | Max time of 18 weeks from point of referral to treatment - incomplete pathway | M | 92% | 98.06% | 97% | 99.82% | 100% | 97.31% | 99.16% | 98.92% | 97.58% | 100% | 100.00% | 98.80% | 98.35% | 98.76% | 98.80% | 93.10% | 4 |
| 27 | | Delayed Transfers Of Care | M | 7.50% | 2.69% | 1.64% | 2.06% | 1.96% | 1.70% | 1.80% | 3.49% | 2.89% | 2.42% | 2.91% | 2.78% | 2.12% | 1.83% | 2.73% | | 4 |
| 28 | | % Admissions Gatekept by CRS Teams | M | 95% | 93.28% | 96.30% | 97.20% | 100% | 95.90% | 96.12% | 95.49% | 95.90% | 96.77% | Data avail month 11 | Data avail month end | 95.51% | 97.29% | 95.69% | | 4 |
| 29 | | % SU on CPA Followed up Within 7 Days of Discharge | M | 95% | 98.21% | 100% | 97.86% | 97.70% | 95.35% | 100% | 95.39% | 95.60% | 95.95% | 97.73% | 97.52% | 98.66% | 97.97% | 95.50% | 96.90% | 4 |
| 30 | | % SU on CPA Having Formal Review Within 12 Months | M | 95% | 96.37% | 95.18% | 97.92% | 96% | 86.57% | 98.44% | 86.88% | 97.52% | 98.56% | 98.32% | 96.72% | 97.92% | 98.44% | 98.56% | 97.67% | 4 |
| 31 | | Meeting commitment to serve new psychosis cases by early intervention teams QTD | M | 95% | 108.97% | 102% | 104.60% | 147.59% | 108.97% | 113.25% | 83.42% | 99.48% | 102.51% | 64.10% | Data avail month end | 104.60% | 113.25% | 102.51% | | 4 |
| 32 | | Data completeness: comm services - Referral to treatment information | M | 50% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.00% | 100.00% | 100% | 100% | 100.00% | 100.00% | | 4 |
| 33 | | Data completeness: comm services - Referral information | M | 50% | 94.00% | 94% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | | 4 |
| 34 | | Data completeness: comm services - Treatment activity information | M | 50% | 94.00% | 94% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | | 4 |
| 35 | | Data completeness: Identifiers (mental health) | M | 97% | 99.70% | 100% | 99.62% | 100% | 99.62% | 99.54% | 99.65% | 99.55% | 99.45% | 99.25% | 99% | 99.62% | 99.54% | 99.45% | | 4 |
| 36 | | Data completeness: Outcomes for patients on CPA | M | 50% | 78.83% | 79.07% | 77.63% | 78.67% | 77.64% | 76.97% | 78.40% | 77.94% | 78.58% | 78.13% | 76.84% | 77.63% | 76.97% | 78.58% | | 4 |
| 37 | | 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 |
| 38 | | IAPT - Treatment within 6 Weeks of referral | M | 75% | 81.46% | 76.52% | 75.72% | 73.70% | 75.83% | 77.98% | 75.31% | 72.28% | 65.66% | 70.06% | 70.04% | 77.84% | 75.91% | 71.62% | | |
| 39 | | IAPT - Treatment within 18 weeks of referral | M | 95% | 98.60% | 98.90% | 99.74% | 99.09% | 98.89% | 99.38% | 99.38% | 99.67% | 99.10% | 98.15% | 97.47% | 99.09% | 99.15% | 99.37% | | |
| 40 | | Early Intervention in Psychosis - 2 weeks (NICE approved care package) | M | 50% | 40.00% | 81.82% | 58.33% | 56.25% | 55.56% | 80.00% | 66.67% | 84.60% | See below for new criteria. | | | | | | | |
| | | Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Clock Stops | | 50% | National reporting commenced Q3. | | | | | | | | 85.19% | 90.91% | 88.24% | National reporting commenced Q3 | | 85.19% | | |
| | | Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Waiting at month end | | 50% | National reporting commenced Q3. | | | | | | | | 25.00% | 93.75% | 60% | National reporting commenced Q3 | | 25.00% | | |
| 43 | Data Quality | % Valid NHS Number | C (FP) | 99% | 99.87% | 100% | 99.88% | 99.71% | 99.58% | 99.76% | 99.58% | 99.30% | 94.11% | 99.58% | 99.63% | 99.88% | | | | 4 |
| 44 | | % Valid Ethnic Coding | C (FP) | 90% | 99.05% | 95% | 94.86% | 94.88% | 94.90% | 94.83% | 94.73% | 94.12% | 99.31% | 99.62% | 94.44% | 96.28% | | | | 4 |

# Strategic Overview Dashboard

## Fit for the future Workforce

| 45 | Section | KPI | Source | Target | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Q1 | Q2 | Q3 | National Average | Year End Forecast Position |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 46 | Sickness | Sickness Absence Rate (YTD) | L | 4.4% | 4.80% | 5.10% | 5.00% | 4.80% | 4.80% | 4.90% | 4.90% | 4.90% | 5.00% | 5.00% | 5.00% | 5.00% | 4.90% | 5.00% | | 1 |
| 47 | Appraisal | Appraisal Rate Band 6 and above | L | 95% | Avail M3 | Avail M3 | 56.80% | 72.90% | 80.30% | 87.30% | 89.50% | 91.60% | 92.90% | 94.50% | 97.33% | 56.80% | 87.30% | 92.90% | | 4 |
| 48 | | Appraisal Rate Band 5 and below | L | 95% | Avail M6 | Avail M6 | Avail M6 | Avail M6 | Avail M6 | 66.30% | 75.80% | 80.30% | 83.60% | 89.20% | 96.59% | Avail M6 | 66.30% | 83.60% | | 4 |
| 50 | Mandatory Training | Aggression Management | L | 80% | 73.70% | 73.65% | 75.83% | 77.04% | 78.89% | 78.85% | 80.38% | 80.78% | 83.12% | 82.53% | 83.18% | 75.83% | 78.85% | 83.12% | | 1 |
| 51 | | Equality, Diversity & Inclusion | L | 80% | 82.30% | 84.55% | 84.87% | 85.76% | 87.17% | 88.28% | 88.81% | 89.37% | 90.31% | 90.58% | 91.39% | 84.87% | 88.28% | 90.31% | | 4 |
| 52 | | Fire Safety | L | 80% | 86.50% | 86.24% | 86.31% | 86.55% | 86.44% | 85.33% | 84.60% | 84.83% | 85.56% | 83.78% | 86.66% | 86.31% | 85.33% | 85.56% | | 4 |
| 57 | | Food Safety | L | 80% | 65.20% | 66.89% | 69.00% | 70.67% | 71.80% | 73.06% | 74.30% | 74.10% | 75.79% | 75.36% | 76.99% | 69.00% | 73.06% | 75.79% | | 1 |
| 54 | | Infection, Prevention & Control & Hand Hygiene | L | 80% | 80.60% | 82.09% | 82.82% | 83.69% | 85.25% | 85.55% | 85.58% | 84.86% | 85.84% | 86.52% | 88.24% | 82.82% | 85.55% | 85.84% | | 4 |
| 55 | | Information Governance | L | 95% | 91.90% | 92.55% | 92.67% | 92.76% | 92.73% | 91.96% | 91.56% | 90.58% | 89.06% | 82.42% | 95.12% | 92.67% | 91.96% | 89.06% | | 4 |
| 56 | | Safeguarding Adults | L | 80% | 82.80% | 82.60% | 84.14% | 84.95% | 86.16% | 86.94% | 87.74% | 87.34% | 88.34% | 88.65% | 89.40% | 84.14% | 86.94% | 88.34% | | 4 |
| 57 | | Safeguarding Children | L | 80% | 84.70% | 85.22% | 86.00% | 86.39% | 87.12% | 87.93% | 86.12% | 85.54% | 87.68% | 88.22% | 89.21% | 86.00% | 87.93% | 87.68% | | 4 |
| 58 | | Moving & Handling | L | 80% | 71.80% | 73.66% | 75.31% | 77.40% | 79.32% | 80.37% | 82.11% | 83.03% | 83.83% | 84.57% | 85.89% | 75.31% | 80.37% | 83.83% | | 1 |
| 59 | Safer Staffing | Safer Staffing - Fill Rate (Nurses) | L | 90% | 91.80% | 94.20% | 96.30% | 94.40% | 91.10% | 92.80% | 95.90% | 97.60% | 93.90% | 93.70% | | 96.30% | 92.80% | | | 4 |
| 60 | | Safer Staffing - Fill Rate (HCA's) | L | 90% | 117.60% | 118.60% | 115.40% | 112.90% | 112.90% | 111.90% | 116.10% | 113.60% | 114.30% | 116.00% | | 115.40% | 111.90% | | | 4 |

| 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 |

# Finance

## Overall Financial Performance 2015 / 2016

| Performance Indicator | | Month 11 Performance | Annual Forecast | Trend from last month | Last 3 Months - Most recent | | |
|---|---|---|---|---|---|---|---|
| Trust Targets | | | | | 10 | 9 | 8 |
| 1 | Monitor Risk Rating | ● | ● | ↓ | ● | ● | ● |
| 2 | REVISED £0.10m Surplus on Income & Expenditure | ● | ● | ↓ | ● | ● | ● |
| 3 | Cash Position | ● | ● | ↓ | ● | ● | ● |
| 4 | Capital Expenditure | ● | ● | ↔ | ● | ● | ● |
| 5 | Delivery of CIP | ● | ● | ↔ | ● | ● | ● |
| 6 | Better Payment Practice Code | ● | ● | ↑ | ● | ● | ● |

**Key**

| | |
|---|---|
| ● | In line, or greater than plan |
| ● | Variance from plan ranging from 5% to 15% |
| ● | Variance from plan greater than 15% |

## Summary Financial Performance

Overall the Trust is reporting a year to date deficit in February 2016 of £1.93 million which is £2.75 million behind the revised plan agreed with Monitor at Month 6. This is due predominantly to a delay in the sale of a Trust asset which had been expected to be completed in February 2016. We still anticipate that this sale will complete before the end of the financial year and as such are reporting Green performance against the annual I&E performance with an expectation that the £100,000 planned surplus will be achieved.

Unfortunately, the impact of this delay on our year to date position has affected our in month monitor risk rating. The February rating is a 3 (against a maximum of 4) which is showing as Red. We do not anticipate there will be any repercussions of this deterioration as long as the forecast position is achieved.

As at February 2016 the Trust Cost Improvement Programme is £1.15 million (13%) behind plan which is included in the financial position. The full year forecast performance against CIP is an under delivery of £1.35 million (14%) representing a small improvement from the January 2016 forecast position. We continue to work closely with budget holders to understand this position and the potential impact on 2016/17 plans.

Due to the delay in the sale of the Trust asset the cash position at the end of February 2016 is also behind plan although still showing an increase since January 2016. Although the sale of the asset is expected to be completed in March the cash transaction may not be achieved before the end of the financial year with the potential to impact on our year end cash position although this should not affect our Monitor rating.

Capital expenditure is £1.6 million (15%) behind plan at £9.15 million. This is predominantly due to the timing of IM&T purchases. As all orders have now been placed we are confident that this will be included in the March position resulting in the previously reported £500,000 underspend against the capital plan.

The Trust is committed to delivering against the Better Payment Practice Code. Performance at February is 96% of non NHS invoices and 91% of NHS invoices being paid within 30 days of receipt.

# Contracting

**Trust Summary by BDU - Current Contract Performance - Position at month 10**

| Contract Variations | In progress | Completed | TOTAL |
|---|---|---|---|
| B BDU | £0.0 | £1,013.0 | £1,013.0 |
| W BDU | £0.0 | £62.2 | £62.2 |
| C BDU | £3.7 | £0.0 | £3.7 |
| K BDU | £0.0 | £0.0 | £0.0 |
| S DBU | £277.1 | £94.0 | £371.1 |
| F BDU | £0.0 | £0.0 | £0.0 |
| TOTAL CVs | £280.8 | £1,169.2 | £1,450.0 |

**QIPP Targets & Delivery for 2015/16**

| CCG | Target £000s | Planned £000s | Remainder £000s | RAG |
|---|---|---|---|---|
| Wakefield* | £1,790.0 | £1,843.3 | £53.3 | *** |
| Kirklees** | £1,000.0 | £689.9 | -£310.1 | |
| Calderdale | £0.0 | £0.0 | £0.0 | |
| TOTAL £000s | £2,790.0 | £2,533.2 | -£256.8 | |

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme
*** W RAG remains at R as risks identified ~ see summary below

**CQUIN Performance**

| Quarter | Quarter 3 £000s | Achieved | Variance | Q4 Forecast based on M10 Performance | Variance |
|---|---|---|---|---|---|
| Barnsley | £426.6 | £378.6 | -£48.0 | £489.8 | -£92.8 |
| Wakefield | £136.1 | £70.7 | -£65.4 | £115.8 | -£177.2 |
| Kirklees | £150.3 | £76.6 | -£73.7 | £127.3 | -£194.2 |
| Calderdale | £67.4 | £34.4 | -£33.1 | £57.1 | -£87.2 |
| Specialised | £75.4 | £75.4 | £0.0 | £56.5 | -£18.9 |
| Forensics | £22.5 | £22.5 | £0.0 | £397.4 | £0.0 |
| Trust Total | £878.4 | £658.2 | -£220.1 | £1,244.0 | -£570.3 |

**Key Points -**

The CQUIN forecast is for significant underperformance in 15/16 linked to non-achievement of clustering targets.
All services using RiO are impacted due to implementation of version 7. We are negotiating extenuating circumstances with Commissioners.
QIPP schemes agreed in 15/16 are making good progress.

**CQUIN Performance Year-end Forecast**

| Quarter | Annual £000s | Forecast Achievement | Variance |
|---|---|---|---|
| Barnsley | £1,790.1 | £1,441.3 | -£348.8 |
| Wakefield | £793.9 | £465.6 | -£328.4 |
| Kirklees | £878.2 | £495.0 | -£383.3 |
| Calderdale | £394.1 | £200.1 | -£194.0 |
| Specialised | £301.7 | £282.8 | -£18.9 |
| Forensics | £562.3 | £562.3 | £0.0 |
| Trust Total | £4,720.4 | £3,447.1 | -£1,273.3 |

**KPIs and Penalties**

| Commissioner | Penalty £000s | Comment |
|---|---|---|
| Barnsley CCG | £6.0 | MSK as at Mth 10 |

**Key Contract Issues - Kirklees**

Psychology 18 week pathway target is being maintained. IAPT is currently below target for recovery, 6 and 18 week waits. A number of areas of investment are being discussed with commissioners including police liaison, early intervention in Psychosis and CAMHS.

**Key Contract Issues - Specialist**

CAMHS – Future in Mind: additional investment made in 15/16 in all areas. The total funds available in 16/17 are £2.3m. We are working through extension the of CAMHS contract in Calderdale and Kirklees in 16/17. Calderdale & Kirklees CAMHS services wil be out to tender in 17/18.
All services impacted by implementation of RiO v7 with a reduction in outcomed appointments logged on the system.
Learning disabilities: in line with the Transformation and staff consultation, we are working on the implementation of the agreed model through contracts.

**Key Contract Issues - Calderdale**

We have been successful in achieving Qualified Provider status for IAPT in Calderdale. No significant issues in terms of contract performance. Key issue in contract negotiations is to ensure services are appropriately funded. This includes police liaison, intensive home based treatment, early intervention in Psychosis, CAMHS and dementia services.

**Key Contract Issues - Forensics**

We are mobilising the Forensic CAMHS prison service for 1st April start of contract. We are awaiting the outcome of a bid for Women's prison services. No significant issues with 15/16 contract. We are awaiting the response from the

**Key Contract Issues - Health & Wellbeing**

There is continued pressure in meeting smoking cessation targets. The 16/17 Health & Well Being contract in Wakefield is still subject to negotiation.

**Key Contract Issues - Wakefield**

No significant performance issues. 16/17 contract with CCG expected to be completed within timescale.

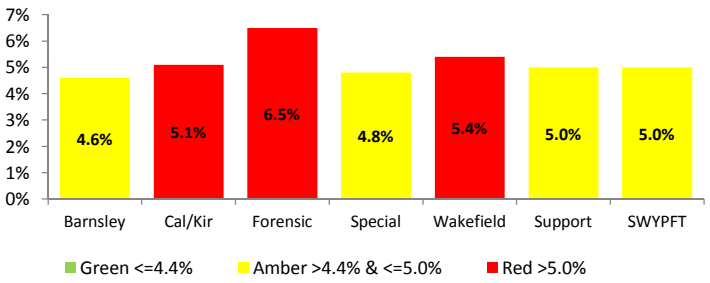
**Key Contract Issues - Barnsley**

The key contract issues are the resolution of the 0-19 contract position and substance misuse; both of which are commissioned by Barnsley MBC.
16/17 contract with CCG is expected to be completed within timescale.

# Workforce

## Human Resources Performance Dashboard - February 2016

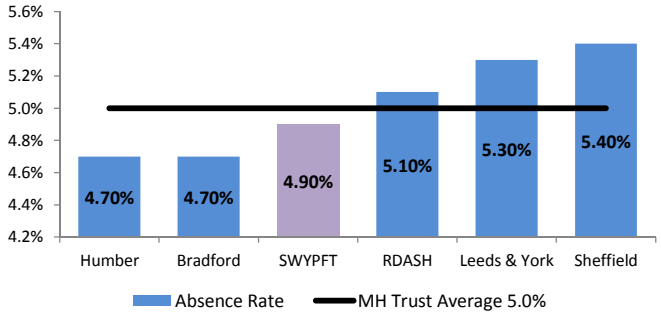
### Sickness Absence




**Current Absence Position - January 2016**

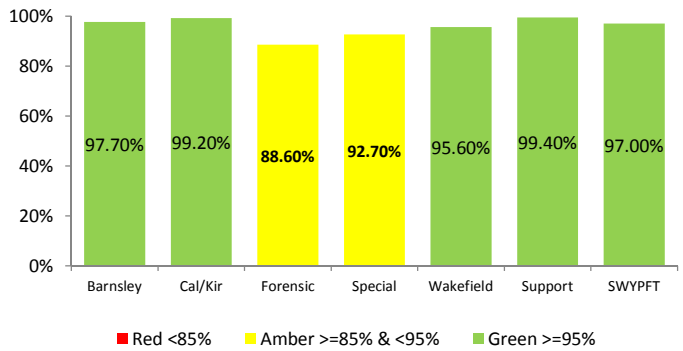
| | Barn | Cal/Kir | Fore | Spec | Wake | Supp | SWYPFT |
|---|---|---|---|---|---|---|---|
| Rate | 5.9% | 5.9% | 5.3% | 4.6% | 5.0% | 4.9% | 5.5% |
| Trend | ↓ | ↔ | ↔ | ↔ | ↔ | ↑ | ↓ |

The Trust YTD absence levels in January 2016 (chart above) were above the 4.4% target at 5%.



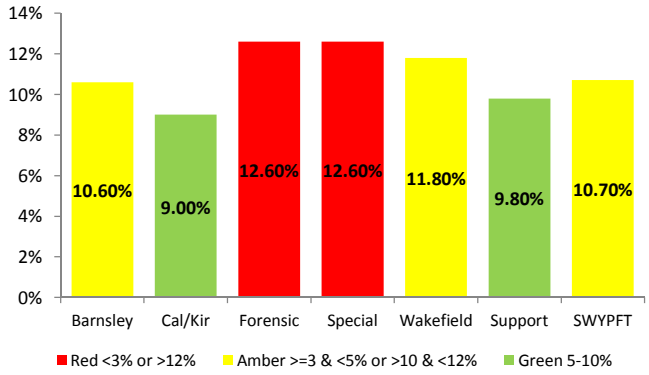

The above chart shows the YTD absence levels in MH/LD Trusts in our region to the end of September 2015. During this time the Trust's absence rate was 4.9% which is below the regional average of 5%.

### Appraisals - All Staff

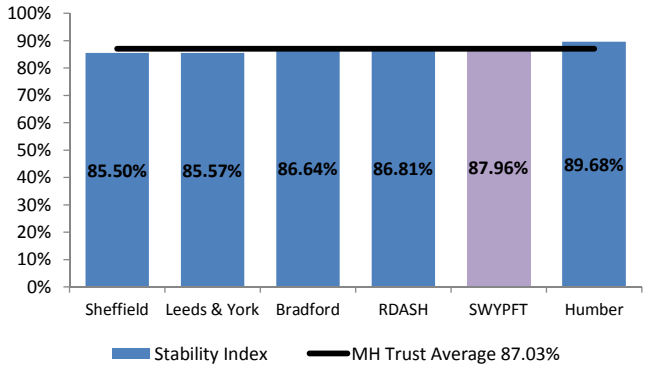



The above chart shows the YTD appraisal rates for all Trust staff to the end of February 2016.
The Trust's target for appraisals is 95% or above.
All areas have shown improvement each month since the inclusion of Bands 1 to 5 in the figures in September 2015.

### Turnover and Stability Rate Benchmark

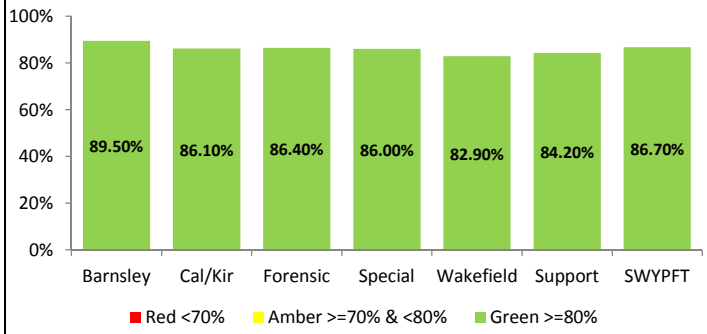



This chart shows the YTD turnover levels up to the end of February 2016.




This chart shows stability levels in MH Trusts in the region for the 12 months ending in October 2015. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is better than the average compared with other MH/LD Trusts in our region.

### Fire Lecture Attendance




The chart shows the YTD fire lecture figures to the end of February 2016.
The Trust continues to achieve its 80% target for fire lecture training, with all areas having maintained their figures above target for several months.

# Workforce - Performance Wall

## Trust Performance Wall

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.80% | 4.90% | 4.90% | 5.00% | 5.00% | 5.00% |
| Sickness (Monthly) | <=4.4% | 5.00% | 4.90% | 5.30% | 5.40% | 5.00% | 5.50% |
| Appraisals (Band 6 and above) | >=95% | 87.30% | 89.50% | 91.60% | 92.80% | 94.50% | 97.30% |
| Appraisals (Band 5 and below) | >=95% | 66.30% | 75.80% | 80.10% | 83.50% | 89.20% | 96.60% |
| Aggression Management | >=80% | 78.90% | 80.40% | 80.80% | 83.10% | 82.50% | 83.20% |
| Equality and Diversity | >=80% | 88.30% | 88.80% | 89.40% | 90.30% | 90.60% | 91.40% |
| Fire Safety | >=80% | 85.30% | 84.60% | 84.80% | 85.60% | 83.80% | 86.70% |
| Food Safety | >=80% | 73.10% | 74.30% | 74.10% | 75.80% | 75.40% | 77.00% |
| Infection Control and Hand Hygiene | >=80% | 85.50% | 85.60% | 84.90% | 85.80% | 86.50% | 88.20% |
| Information Governance | >=95% | 92.00% | 91.60% | 90.60% | 89.10% | 82.40% | 95.10% |
| Moving and Handling | >=80% | 80.40% | 82.10% | 83.00% | 83.80% | 84.60% | 85.90% |
| Safeguarding Adults | >=80% | 86.90% | 87.70% | 87.30% | 88.30% | 88.70% | 89.40% |
| Safeguarding Children | >=80% | 87.90% | 86.10% | 85.50% | 87.70% | 88.20% | 89.20% |
| Bank Cost | | £488k | £478k | £428k | £414k | £426k | £419k |
| Agency Cost | | £637k | £772k | £770k | £606k | £527k | £774k |
| Overtime Cost | | £38k | £30k | £37k | £22k | £31k | £30k |
| Additional Hours Cost | | £67k | £74k | £87k | £89k | £64k | £70k |
| Sickness Cost (Monthly) | | £482k | £475k | £546k | £533k | £515k | £576k |
| Vacancies (Non-Medical) (WTE) | | 351.54 | 324.2 | 306.46 | 316.89 | 353.49 | 380.25 |
| Business Miles | | 270k | 333k | 347k | 323k | 327k | 323k |

## Barnsley District

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.10% | 4.20% | 4.50% | 5.10% | 5.20% | 5.90% |
| Sickness (Monthly) | <=4.4% | 90.50% | 92.10% | 94.40% | 95.60% | 97.20% | 98.20% |
| Appraisals (Band 6 and above) | >=95% | 73.40% | 83.30% | 87.50% | 89.80% | 92.10% | 97.20% |
| Appraisals (Band 5 and below) | >=95% | 83.60% | 83.50% | 82.90% | 84.10% | 80.80% | 82.60% |
| Aggression Management | >=80% | 90.40% | 90.70% | 91.30% | 92.60% | 93.00% | 93.60% |
| Equality and Diversity | >=80% | 85.90% | 84.70% | 85.80% | 86.20% | 85.80% | 89.50% |
| Fire Safety | >=80% | 80.70% | 80.10% | 75.70% | 74.90% | 72.70% | 74.20% |
| Food Safety | >=80% | 86.60% | 86.40% | 87.00% | 88.10% | 87.80% | 90.50% |
| Infection Control and Hand Hygiene | >=80% | 91.70% | 92.10% | 90.90% | 90.50% | 86.40% | 96.20% |
| Information Governance | >=95% | 82.60% | 84.50% | 85.10% | 86.10% | 86.40% | 88.10% |
| Moving and Handling | >=80% | 88.90% | 90.00% | 89.20% | 89.80% | 90.10% | 91.00% |
| Safeguarding Adults | >=80% | 89.20% | 87.90% | 87.40% | 89.00% | 89.40% | 90.40% |
| Safeguarding Children | >=80% | £84k | £85k | £75k | £65k | £61k | £61k |
| Bank Cost | | £157k | £119k | £200k | £130k | £170k | £168k |
| Agency Cost | | £19k | £10k | £17k | £8k | £17k | £16k |
| Overtime Cost | | £31k | £35k | £40k | £36k | £33k | £33k |
| Additional Hours Cost | | £137k | £138k | £155k | £175k | £199k | £230k |
| Sickness Cost (Monthly) | | 100.85 | 92.75 | 85.33 | 87.34 | 108.19 | 124.09 |
| Vacancies (Non-Medical) (WTE) | | 111k | 144k | 148k | 126k | 132k | 135k |
| Business Miles | | | | | | | |

## Calderdale and Kirklees District

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.70% | 4.80% | 5.00% | 5.10% | 5.00% | 5.10% |
| Sickness (Monthly) | <=4.4% | 5.20% | 5.10% | 6.60% | 5.60% | 4.80% | 5.90% |
| Appraisals (Band 6 and above) | >=95% | 97.50% | 98.80% | 99.70% | 99.10% | 99.70% | 100.00% |
| Appraisals (Band 5 and below) | >=95% | 76.50% | 85.00% | 88.80% | 91.70% | 92.50% | 98.40% |
| Aggression Management | >=80% | 83.00% | 83.20% | 82.80% | 86.10% | 87.30% | 87.20% |
| Equality and Diversity | >=80% | 89.80% | 90.60% | 91.60% | 92.00% | 93.20% | 92.40% |
| Fire Safety | >=80% | 85.40% | 83.00% | 83.20% | 85.40% | 83.00% | 86.10% |
| Food Safety | >=80% | 67.70% | 69.50% | 70.20% | 72.00% | 74.50% | 74.10% |
| Infection Control and Hand Hygiene | >=80% | 88.60% | 88.60% | 90.00% | 90.40% | 91.10% | 90.70% |
| Information Governance | >=95% | 92.80% | 90.40% | 89.80% | 87.50% | 83.30% | 96.30% |
| Moving and Handling | >=80% | 78.80% | 81.30% | 82.70% | 83.40% | 84.30% | 85.20% |
| Safeguarding Adults | >=80% | 85.20% | 86.60% | 86.80% | 88.20% | 88.90% | 88.50% |
| Safeguarding Children | >=80% | 87.20% | 86.20% | 86.50% | 89.40% | 91.00% | 90.40% |
| Bank Cost | | £134k | £117k | £124k | £114k | £123k | £147k |
| Agency Cost | | £141k | £199k | £173k | £117k | £124k | £182k |
| Overtime Cost | | £1k | £1k | £2k | £0k | £3k | £0k |
| Additional Hours Cost | | £2k | £2k | £3k | £3k | £2k | £5k |
| Sickness Cost (Monthly) | | £105k | £101k | £142k | £116k | £97k | £131k |
| Vacancies (Non-Medical) (WTE) | | 82.93 | 71.14 | 75.66 | 72.44 | 69.5 | 64.92 |
| Business Miles | | 57k | 65k | 73k | 61k | 63k | 62k |

## Forensic Services

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 7.30% | 7.20% | 7.00% | 6.80% | 6.60% | 6.50% |
| Sickness (Monthly) | <=4.4% | 6.10% | 6.80% | 5.80% | 5.70% | 5.00% | 5.30% |
| Appraisals (Band 6 and above) | >=95% | 68.60% | 70.00% | 74.70% | 84.70% | 84.10% | 86.60% |
| Appraisals (Band 5 and below) | >=95% | 61.00% | 66.20% | 71.50% | 77.60% | 83.90% | 89.20% |
| Aggression Management | >=80% | 77.40% | 78.20% | 80.70% | 81.70% | 80.60% | 80.20% |
| Equality and Diversity | >=80% | 89.20% | 90.40% | 92.40% | 92.80% | 93.00% | 92.90% |
| Fire Safety | >=80% | 85.50% | 87.30% | 88.60% | 89.00% | 83.10% | 86.40% |
| Food Safety | >=80% | 65.40% | 70.60% | 73.50% | 79.70% | 79.60% | 82.70% |
| Infection Control and Hand Hygiene | >=80% | 85.80% | 85.30% | 84.40% | 85.40% | 87.00% | 88.00% |
| Information Governance | >=95% | 90.70% | 91.70% | 91.90% | 90.80% | 80.60% | 93.00% |
| Moving and Handling | >=80% | 84.00% | 85.80% | 87.60% | 87.90% | 88.80% | 89.20% |
| Safeguarding Adults | >=80% | 85.50% | 88.50% | 89.90% | 91.50% | 91.90% | 92.10% |
| Safeguarding Children | >=80% | 84.50% | 85.30% | 85.90% | 87.70% | 85.20% | 86.10% |
| Bank Cost | | £114k | £114k | £97k | £86k | £108k | £77k |
| Agency Cost | | £96k | £122k | £68k | £68k | £92k | £143k |
| Overtime Cost | | £0k | £0k | £0k | £0k | £0k | £1k |
| Additional Hours Cost | | £57k | £58k | £56k | £50k | £40k | £44k |
| Sickness Cost (Monthly) | | 14.34 | 24.94 | 24.54 | 37.11 | 45.11 | 49.62 |
| Vacancies (Non-Medical) (WTE) | | 3k | 9k | 9k | 12k | 7k | 4k |
| Business Miles | | | | | | | |

# Workforce - Performance Wall cont…

## Specialist Services

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.10% | 5.10% | 5.00% | 4.80% | 4.80% | 4.80% |
| Sickness (Monthly) | <=4.4% | 5.00% | 4.70% | 4.60% | 3.80% | 4.40% | 4.60% |
| Appraisals (Band 6 and above) | >=95% | 60.50% | 68.70% | 73.80% | 75.10% | 77.90% | 91.80% |
| Appraisals (Band 5 and below) | >=95% | 44.00% | 47.50% | 53.60% | 64.80% | 71.30% | 94.00% |
| Aggression Management | >=80% | 73.40% | 76.40% | 77.10% | 79.80% | 81.20% | 81.60% |
| Equality and Diversity | >=80% | 89.60% | 89.90% | 90.00% | 90.50% | 90.10% | 91.30% |
| Fire Safety | >=80% | 82.20% | 83.20% | 82.10% | 84.60% | 85.10% | 86.00% |
| Food Safety | >=80% | 69.10% | 69.00% | 71.20% | 73.70% | 73.20% | 74.50% |
| Infection Control and Hand Hygiene | >=80% | 83.80% | 84.00% | 84.30% | 85.90% | 86.30% | 87.40% |
| Information Governance | >=95% | 89.10% | 90.10% | 90.20% | 89.50% | 85.20% | 95.90% |
| Moving and Handling | >=80% | 82.20% | 82.50% | 83.10% | 83.10% | 84.80% | 85.70% |
| Safeguarding Adults | >=80% | 84.70% | 83.20% | 82.00% | 84.40% | 84.80% | 86.60% |
| Safeguarding Children | >=80% | 85.40% | 84.90% | 81.30% | 85.60% | 87.70% | 87.80% |
| Bank Cost | | £38k | £31k | £28k | £32k | £25k | £21k |
| Agency Cost | | £127k | £228k | £216k | £146k | £59k | £173k |
| Overtime Cost | | £2k | £1k | £1k | £1k | £2k | £2k |
| Additional Hours Cost | | £7k | £5k | £7k | £11k | £4k | £9k |
| Sickness Cost (Monthly) | | £54k | £53k | £55k | £45k | £43k | £44k |
| Vacancies (Non-Medical) (WTE) | | 50.41 | 45.31 | 44.49 | 40.71 | 39.15 | 49.08 |
| Business Miles | | 29k | 30k | 39k | 40k | 36k | 37k |

## Support Services

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.70% | 4.70% | 4.80% | 5.00% | 5.00% | 5.00% |
| Sickness (Monthly) | <=4.4% | 5.30% | 4.80% | 5.40% | 6.00% | 5.40% | 4.90% |
| Appraisals (Band 6 and above) | >=95% | 94.80% | 95.90% | 96.50% | 96.90% | 98.50% | 99.00% |
| Appraisals (Band 5 and below) | >=95% | 54.80% | 71.10% | 72.70% | 74.80% | 89.70% | 99.60% |
| Aggression Management | >=80% | 68.60% | 72.40% | 74.30% | 78.60% | 78.50% | 78.90% |
| Equality and Diversity | >=80% | 78.10% | 78.70% | 78.90% | 80.40% | 80.90% | 84.10% |
| Fire Safety | >=80% | 86.00% | 84.60% | 84.30% | 83.50% | 80.90% | 84.20% |
| Food Safety | >=80% | 93.60% | 90.10% | 89.20% | 89.90% | 87.30% | 91.00% |
| Infection Control and Hand Hygiene | >=80% | 81.20% | 82.30% | 76.80% | 78.30% | 79.20% | 82.00% |
| Information Governance | >=95% | 92.80% | 91.70% | 89.60% | 86.60% | 71.30% | 90.90% |
| Moving and Handling | >=80% | 78.80% | 81.10% | 81.50% | 81.90% | 82.70% | 84.80% |
| Safeguarding Adults | >=80% | 84.80% | 84.90% | 84.50% | 85.40% | 85.90% | 86.90% |
| Safeguarding Children | >=80% | 90.30% | 83.70% | 82.80% | 84.80% | 85.50% | 88.60% |
| Bank Cost | | £35k | £60k | £14k | £39k | £38k | £42k |
| Agency Cost | | £103k | £71k | £40k | £74k | £33k | £42k |
| Overtime Cost | | £0k | £4k | £0k | £0k | | £0k |
| Additional Hours Cost | | £19k | £22k | £19k | £20k | £17k | £13k |
| Sickness Cost (Monthly) | | £69k | £61k | £68k | £84k | £80k | £72k |
| Vacancies (Non-Medical) (WTE) | | 42.54 | 51.48 | 36.73 | 37.2 | 43.98 | 41.82 |
| Business Miles | | 38k | 42k | 35k | 48k | 45k | 42k |

## Wakefield District

| Month | | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.30% | 5.30% | 5.40% | 5.50% | 5.40% | 5.30% |
| Sickness (Monthly) | <=4.4% | 5.70% | 5.60% | 5.90% | 5.80% | 4.80% | 5.00% |
| Appraisals (Band 6 and above) | >=95% | 87.40% | 88.10% | 90.20% | 91.80% | 95.10% | 97.90% |
| Appraisals (Band 5 and below) | >=95% | 64.30% | 68.40% | 76.70% | 81.30% | 87.00% | 93.90% |
| Aggression Management | >=80% | 79.30% | 82.90% | 82.80% | 84.20% | 82.10% | 83.80% |
| Equality and Diversity | >=80% | 91.70% | 92.20% | 92.20% | 92.60% | 91.50% | 92.70% |
| Fire Safety | >=80% | 84.60% | 86.10% | 84.70% | 85.20% | 82.50% | 82.90% |
| Food Safety | >=80% | 67.60% | 68.60% | 69.70% | 69.50% | 68.80% | 70.40% |
| Infection Control and Hand Hygiene | >=80% | 84.10% | 83.80% | 81.80% | 82.00% | 85.30% | 86.70% |
| Information Governance | >=95% | 93.30% | 92.60% | 91.50% | 89.00% | 84.40% | 97.00% |
| Moving and Handling | >=80% | 73.60% | 74.00% | 75.70% | 77.60% | 78.30% | 79.00% |
| Safeguarding Adults | >=80% | 89.70% | 89.70% | 88.90% | 89.00% | 88.20% | 89.70% |
| Safeguarding Children | >=80% | 86.40% | 85.60% | 85.30% | 86.30% | 86.40% | 87.70% |
| Bank Cost | | £83k | £71k | £90k | £78k | £72k | £71k |
| Agency Cost | | £12k | £34k | £73k | £71k | £49k | £66k |
| Overtime Cost | | £16k | £14k | £14k | £12k | £10k | £12k |
| Additional Hours Cost | | £9k | £9k | £13k | £12k | £7k | £9k |
| Sickness Cost (Monthly) | | £60k | £63k | £70k | £64k | £55k | £56k |
| Vacancies (Non-Medical) (WTE) | | 55.47 | 36.58 | 34.71 | 40.49 | 45.96 | 48.79 |
| Business Miles | | 31k | 43k | 44k | 37k | 44k | 43k |

# Publication Summary

**Monitor**

Implementing the Forward View: supporting providers to deliver

This report is for NHS provider organisations and is part of a series of planned roadmaps that draw on messages from the NHS shared planning guidance, and set out the key priorities for the organisations responsible for delivering high quality health and care this year and beyond. Each roadmap will reflect a shared vision for the health and care sector as set out in the NHS five year forward view about the challenges ahead, and the choices to be faced about the kind of health and care service required in 2020.
Click here for report

**Monitor**

2016/17 national tariff payment system: a consultation

This consultation seeks feedback on proposals which are aimed at giving commissioners and NHS providers the space to manage increasing demand, restore financial balance, and to make ambitious longer term plans to improve patient care. Monitor and NHS England are specifically seeking views on the approach to price setting for 2016/17; the impact of the proposed changes to the national tariff; the proposals for local payment arrangements; and the approach to enforcing the national tariff. The
Click here for consultation

**NHS England**

The Five Year Forward View for mental health

This is the final report of an independent taskforce set up by NHS England as part of its Five year forward view to build consensus on how to improve services for people of all ages. It gives a frank assessment of the state of current mental health care across the NHS, highlighting that one in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is £105bn a year. The report proposes a three-pronged approach to improving care through prevention, the expansion of mental health care such as seven day access in a crisis, and integrated physical and mental health care.
Click here for report

**Care Quality Commission (CQC)**

CQC's strategy 2016 to 2021: shaping the future - consultation document

This is the third in a series of documents in which the CQC have asked for help to develop a strategy for the next five years. This consultation covers: their vision for regulating the quality of health and adult social care services; the proposals set out on how the CQC aim to achieve this; and the equality, diversity and human rights impacts which have been considered. The consultation is open until 14 March 2016.

Click here for consultation

# Publication Summary cont….

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

Bed availability and occupancy: Quarter ending December 2015

Statistics » Direct Access Audiology waiting times for December 2015

Mixed Sex Accommodation Breached - January 2016

NHS foundation trust bulletin: 17 February 2016

Improving access to psychological therapies report, November 2015 final, December 2015 primary and most recent quarterly data (Q2 2015/16)

Mental health and learning disabilities statistics monthly report: final November and provisional December

NHS sickness absence rates: October 2015

NHS workforce statistics: November 2015, provisional statistics

# Glossary

| | |
|---|---|
| ADHD | Attention deficit hyperactivity disorder |
| AQP | Any Qualified Provider |
| 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&K | Calderdale & Kirklees |
| 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 |
| DoV | Deed of Variation |
| DQ | Data Quality |
| DTOC | Delayed Transfers of Care |
| 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 |
| IHBT | Intensive Home Based Treatment |
| IM&T | Information Management & Technology |
| Inf Prevent | Infection Prevention |
| IWMS | Integrated Weight Management Service |
| KPIs | Key Performance Indicators |

| | |
|---|---|
| LD | Learning Disability |
| Mgt | Management |
| 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 |
| NHS TDA | National Health Service Trust Development Authority |
| NHSE | National Health Service England |
| NICE | National Institute for Clinical Excellence |
| NK | North Kirklees |
| OOA | Out of Area |
| OPS | Older People's Services |
| PbR | Payment by Results |
| 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 |
| S BDU | Specialist Services Business Delivery Unit |
| SK | South Kirklees |
| SMU | Substance Misuse Unit |
| SU | Service Users |
| SWYFT | South West Yorkshire Foundation Trust |
| SYBAT | South Yorkshire and Bassetlaw local area team |
| 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

# Finance Report

Month 11 (2015 / 2016)

# Contents

# Overall Financial Performance 2015 / 2016

| Performance Indicator | | Month 11 Performance | Annual Forecast | Trend from last month | Last 3 Months - Most recent | | |
|---|---|---|---|---|---|---|---|
| Trust Targets | | | | | 10 | 9 | 8 |
| 1 | Monitor Risk Rating | ● | ● | ↓ | ● | ● | ● |
| 2 | REVISED £0.10m Surplus on Income & Expenditure | ● | ● | ↓ | ● | ● | ● |
| 3 | Cash Position | ● | ● | ↓ | ● | ● | ● |
| 4 | Capital Expenditure | ● | ● | ⇔ | ● | ● | ● |
| 5 | Delivery of CIP | ● | ● | ⇔ | ● | ● | ● |
| 6 | Better Payment Practice Code | ● | ● | ↑ | ● | ● | ● |

| Key | |
|---|---|
| ● | In line, or greater than plan |
| ● | Variance from plan ranging from 5% to 15% |
| ● | Variance from plan greater than 15% |

## Summary Financial Performance

Overall the Trust is reporting a year to date deficit in February 2016 of £1.93 million which is £2.75 million behind the revised plan agreed with Monitor at Month 6. This is due predominantly to a delay in the sale of a Trust asset which had been expected to be completed in February 2016. We still anticipate that this sale will complete before the end of the financial year and as such are reporting Green performance against the annual I&E performance with an expectation that the £100,000 planned surplus will be achieved.

Unfortunately, the impact of this delay on our year to date position has affected our in month monitor risk rating. The February rating is a 3 (against a maximum of 4) which is showing as Red. We do not anticipate there will be any repercussions of this deterioration as long as the forecast position is achieved.

As at February 2016 the Trust Cost Improvement Programme is £1.15 million (13%) behind plan which is included in the financial position. The full year forecast performance against CIP is an under delivery of £1.35 million (14%) representing a small improvement from the January 2016 forecast position. We continue to work closely with budget holders to understand this position and the potential impact on 2016/17 plans.

Due to the delay in the sale of the Trust asset the cash position at the end of February 2016 is also behind plan although still showing an increase since January 2016. Although the sale of the asset is expected to be completed in March the cash transaction may not be achieved before the end of the financial year with the potential to impact on our year end cash position although this should not affect our Monitor rating.

Capital expenditure is £1.6 million (15%) behind plan at £9.15 million. This is predominantly due to the timing of IM&T purchases. As all orders have now been placed we are confident that this will be included in the March position resulting in the previously reported £500,000 underspend against the capital plan.

The Trust is committed to delivering against the Better Payment Practice Code. Performance at February is 96% of non NHS invoices and 91% of NHS invoices being paid within 30 days of receipt.

# Monitor Risk Rating

As per the Risk assessment Framework, updated August 2015, the financial performance of the Trust is monitored through a number of financial sustainability risk ratings.

This revision increased the number of metrics from 2 to 4. This retains the original 2 which focus on the Continuity of Services and add 2 further in relation to Financial Efficiency. A further metric in relation to capital expenditure performance against plan was proposed but has not been adopted.

| | | | | Actual Performance | | Annual Plan | |
|---|---|---|---|---|---|---|---|
| | Financial Criteria | Weight | Metric | Score | Risk Rating | Score | Risk Rating |
| Continuity of Services | Balance Sheet Sustainability | 25% | Capital Service Capacity | 2.7 | 4 | 3.0 | 4 |
| | Liquidity | 25% | Liquidity (Days) | 13.4 | 4 | 12.0 | 4 |
| | Weighted Average - Continuity of Services Risk Rating | | | | 4 | | 4 |
| Financial Efficiency | Underlying Performance | 25% | I & E Margin | -0.7% | 2 | | |
| | Variance from Plan | 25% | Variance in I & E Margin as a % of income | -1.4% | 2 | | |
| | Weighted Average - Financial Sustainability Risk Rating | | | | 3 | | |

**Definitions**

**Capital Servicing Capacity** - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

**Liquidity** - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

**I & E Margin** - the degree to which the organisation is operating at a surplus / deficit

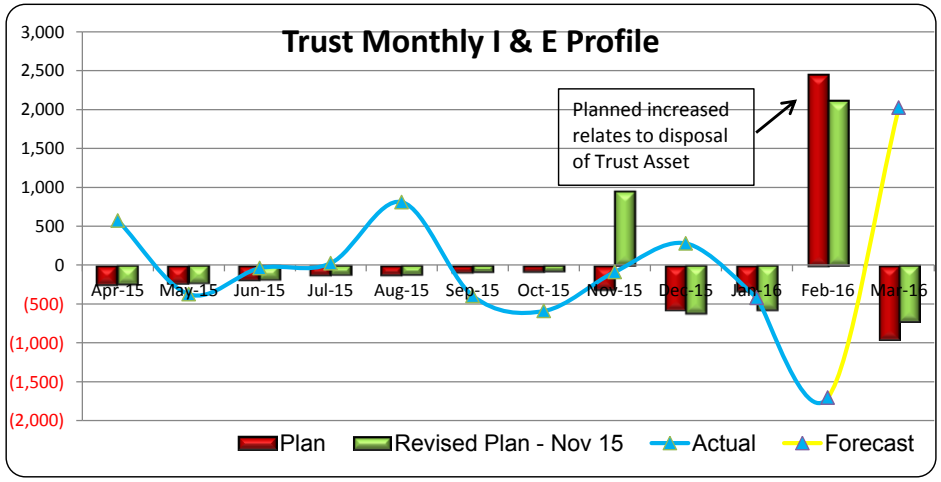
**I & E Variance** - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

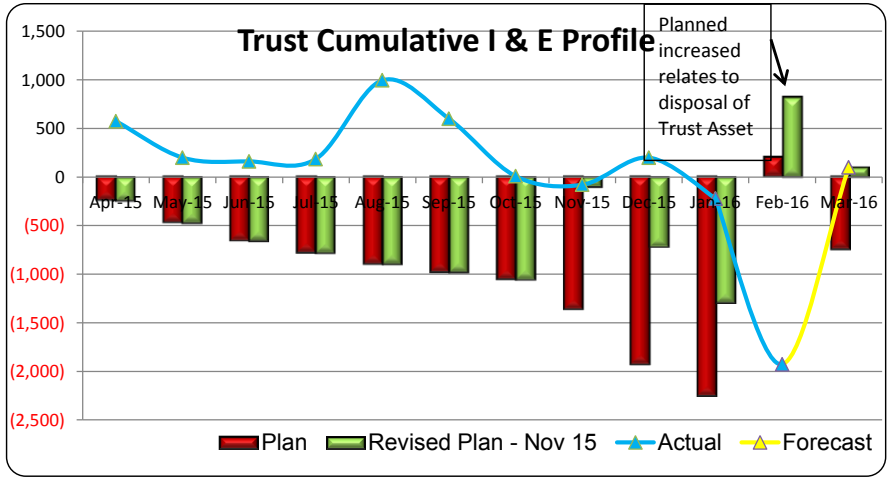
**Risk Rating 4** - No evident Concerns

**Risk Rating 3** - Emerging or minor concern potentially requiring scrutiny.

# Income & Expenditure Position 2015 / 2016

| 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** |
| | | | | | | | | | | | | | |
| | | | | (17,491) | (17,307) | 184 | Clinical Revenue | (193,366) | (192,375) | 991 | (210,812) | (209,810) | 1,002 |
| | | | | **(17,491)** | **(17,307)** | **184** | **Total Clinical Revenue** | **(193,366)** | **(192,375)** | **991** | **(210,812)** | **(209,810)** | **1,002** |
| | | | | (1,256) | (1,362) | (106) | Other Operating Revenue | (14,840) | (15,437) | (596) | (16,042) | (16,917) | (875) |
| | | | | **(18,747)** | **(18,669)** | **78** | **Total Revenue** | **(208,207)** | **(207,812)** | **394** | **(226,854)** | **(226,727)** | **127** |
| | | | | | | | | | | | | | |
| 4,419 | 4,205 | (214) | 4.8% | 14,356 | 14,351 | (5) | BDU Expenditure - Pay | 157,439 | 156,552 | (887) | 171,650 | 170,958 | (692) |
| | | | | 3,691 | 3,797 | 105 | BDU Expenditure - Non Pay | 41,821 | 41,337 | (484) | 46,210 | 47,211 | 1,001 |
| | | | | 585 | 639 | 54 | Provisions | 3,053 | 3,365 | 312 | 3,115 | 2,077 | (1,038) |
| **4,419** | **4,205** | **(214)** | **4.8%** | **18,633** | **18,787** | **154** | **Total Operating Expenses** | **202,313** | **201,254** | **(1,059)** | **220,974** | **220,245** | **(729)** |
| | | | | | | | | | | | | | |
| **4,419** | **4,205** | **(214)** | **4.8%** | **(115)** | **118** | **232** | **EBITDA** | **(5,894)** | **(6,558)** | **(665)** | **(5,880)** | **(6,482)** | **(602)** |
| | | | | 456 | 1,525 | 1,069 | Depreciation | 5,019 | 6,013 | 994 | 5,475 | 6,469 | 994 |
| | | | | 257 | 248 | (9) | PDC Paid | 2,823 | 2,723 | (100) | 3,080 | 2,970 | (110) |
| | | | | (6) | (4) | 2 | Interest Received | (69) | (70) | (1) | (75) | (76) | (1) |
| | | | | (2,700) | (181) | 2,519 | Revaluation of Assets | (2,700) | (181) | 2,519 | (2,700) | (2,981) | (281) |
| **4,419** | **4,205** | **(214)** | **4.8%** | **(2,108)** | **1,705** | **3,813** | **Deficit / (Surplus)** | **(820)** | **1,926** | **2,747** | **(100)** | **(100)** | **0** |



# Income & Expenditure Position 2015 / 2016

**Month 11**

The year to date position, as at Month 11, reflects a deficit position of £1.93m. This is currently £2.75m behind of the revised Trust plan. This revised plan was communicated to Monitor as part of the Quarter 2 Trust submission. This has resulted in a reduction to the in month Monitor Risk Rating although we do not expect the year end rating to change

In month a number of key transactions, contained within the overall forecast, have been actioned within the ledger.

| | | |
|---|---|---|
| Accelerated Depreciation | £1.1m | As a result of the decision to proceed with the Fieldhead Non-Secure capital programme we have accelerated the deprecaition charges for buildings which are going to be demolished. |
| Estates Revaluation | (£0.2m) | This reflects the I & E benefit arising from the Annual Estates Revaluation exercise. Although this revaluation is in line with our expectations, the I&E impact is lower than forecast with a corresponding change to the balance sheet impact. |
| Timing Delay | £2.7m | The sale of a Trust Asset giving rise to a material I & E benefit was forecast to be completed in February but is now expected to be transacted in March 2016. As such the overall year to date position has deteriorated but with no impact on the forecast outturn. |

The month 11 position also reflects the current Quarter 3 CQUIN shortfall in income but discussions continue with Commissioners to minimise the impact of this as far as possible.

Overall, BDU expenditure has been broadly in line with plan in month. This has followed the trend of previous months where underspends on pay and additional BDU operational income has been offset by overspends against non pay expenditure.

**Forecast**

The Trust forecast position remains that the revised plan of £100k surplus (a £842k improvement from the original plan) can be delivered through continued control of expenditure within the BDU's and utilisation of provisions.

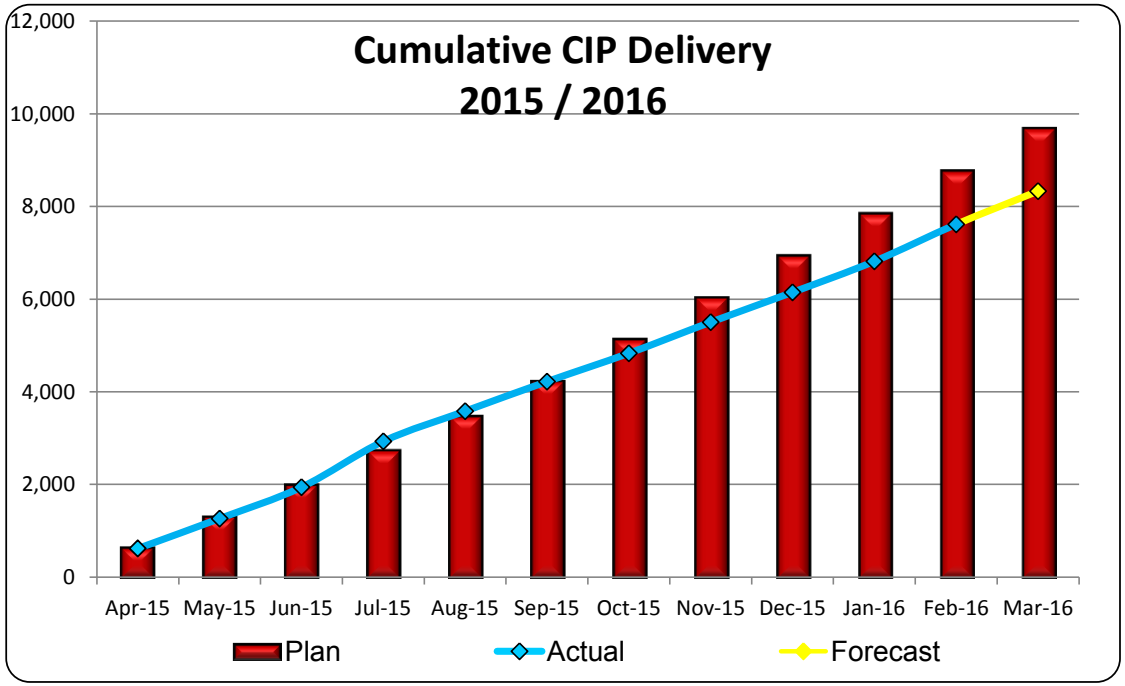
The main risk to delivery of this is the sale of Trust Asset previous highlighted but the Trust retain a level of certainty that this will complete imminently within March 2016.

Based upon the current forecasts, funds within provisions (£1.04m) are being used in order to support this position. This is broadly the same as month 10 as the additional pressures arising from the Accelerated Depreciation charges have been offset by movement in operational forecasts.

Provisions will continue to be monitored and managed in order to ensure that this position is achieved.

# Cost Improvement Programme 2015 / 2016

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k |
| Target - Recurrent | 606 | 613 | 642 | 686 | 690 | 705 | 845 | 850 | 849 | 856 | 856 | 864 | 8,197 | 9,061 |
| Target - Non Recurrent | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 52 | 570 | 622 |
| Target - Monitor Submission | 657 | 664 | 694 | 738 | 742 | 756 | 897 | 902 | 901 | 908 | 908 | 916 | 8,767 | 9,683 |
| Target - Cumulative | 657 | 1,322 | 2,016 | 2,754 | 3,496 | 4,252 | 5,149 | 6,051 | 6,951 | 7,859 | 8,767 | 9,683 | 8,767 | 9,683 |
| | | | | | | | | | | | | | | |
| Delivery as planned | 400 | 806 | 1,226 | 1,751 | 2,197 | 2,643 | 3,101 | 3,627 | 4,112 | 4,615 | 5,147 | 5,692 | 5,147 | 5,692 |
| Mitigations - Recurrent | 11 | 22 | 32 | 45 | 61 | 76 | 92 | 107 | 127 | 147 | 167 | 187 | 167 | 187 |
| Mitigations - Non Recurrent | 205 | 436 | 682 | 1,134 | 1,324 | 1,500 | 1,639 | 1,769 | 1,907 | 2,054 | 2,300 | 2,452 | 2,300 | 2,452 |
| Total Delivery | **616** | **1,264** | **1,940** | **2,930** | **3,582** | **4,220** | **4,831** | **5,503** | **6,147** | **6,816** | **7,614** | **8,331** | **7,614** | **8,331** |
| | | | | | | | | | | | | | | |
| Shortfall / Unidentified | 41 | 58 | 75 | (176) | (86) | 33 | 318 | 547 | 805 | 1,043 | 1,153 | 1,353 | 1,153 | 1,353 |




The profile of the Trust Cost Improvement Programme for 2015 / 2016 is outlined above. This follows a detailed bottom up process conducted as part of the Trust Annual Plan; one which was subjected to an external review.

**Year to Date**

For the Year to Date £7.61m CIP has been achieved out of the £8.77m target. (87%) It is £1153k behind plan.

The CIP acheivement includes £2300k non recurrent substitutions (30% of total delivered).

**Forecast**

The current forecast is that £8.33m out of £9.68m will be achieved in 15/16. This leaves a forecast shortfall of £1.35m (14%) and this is reflected in the Trust overall forecast position.

As part of the Trust Annual Planning Process BDU's have conducted a full, and frank, assessment of recurrent CIP shortfall for 2016 / 2017. Substitutions for this shortfall need to be identified.

# Balance Sheet 2015 / 2016

| | 2014 / 2015 £k | Plan (YTD) £k | Actual (YTD) £k | Note |
|---|---|---|---|---|
| Non-Current (Fixed) Assets | 106,649 | 112,248 | 112,971 | 1 |
| **Current Assets** | | | | |
| Inventories & Work in Progress | 204 | 204 | 204 | |
| NHS Trade Receivables (Debtors) | 3,015 | 1,765 | 2,223 | 2 |
| Other Receivables (Debtors) | 4,963 | 5,213 | 6,973 | 2 |
| Cash and Cash Equivalents | 32,617 | 28,243 | 27,532 | 3 |
| **Total Current Assets** | **40,799** | **35,425** | **36,932** | |
| **Current Liabilities** | | | | |
| Trade Payables (Creditors) | (5,851) | (5,851) | (5,854) | 4 |
| Other Payables (Creditors) | (3,621) | (4,905) | (4,207) | 4 |
| Capital Payables (Creditors) | (770) | (1,720) | (553) | |
| Accruals | (10,335) | (8,835) | (11,702) | 5 |
| Deferred Income | (751) | (751) | (782) | |
| **Total Current Liabilities** | **(21,328)** | **(22,062)** | **(23,098)** | |
| **Net Current Assets/Liabilities** | **19,471** | **13,363** | **13,835** | |
| **Total Assets less Current Liabilities** | **126,120** | **125,611** | **126,805** | |
| Provisions for Liabilities | (8,104) | (7,422) | (7,421) | |
| **Total Net Assets/(Liabilities)** | **118,016** | **118,189** | **119,385** | |
| Taxpayers' Equity | | | | |
| Public Dividend Capital | 43,492 | 43,492 | 43,492 | |
| Revaluation Reserve | 16,780 | 16,780 | 19,639 | |
| Other Reserves | 5,220 | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 52,524 | 52,697 | 51,034 | 6 |
| **Total Taxpayers' Equity** | **118,016** | **118,189** | **119,385** | |

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2015. The previous year end position is included for information.

1. Due to the Estates revaluation exercise, actioned in February 2016, the value of fixed assets are now higher than originally planned.

2. NHS debtors are higher than planned due to continued delays in payment with another Trust. They are also higher as Qtr 3 CQUIN charges were raised prior to month end and remain outstanding. For Non NHS debtors this also continues to be delays with one specific Local Authority.

3. The reconciliation of Actual Cash Flow to Plan compares the current month end position to the Annual Plan position for the same period. This is on page 11.

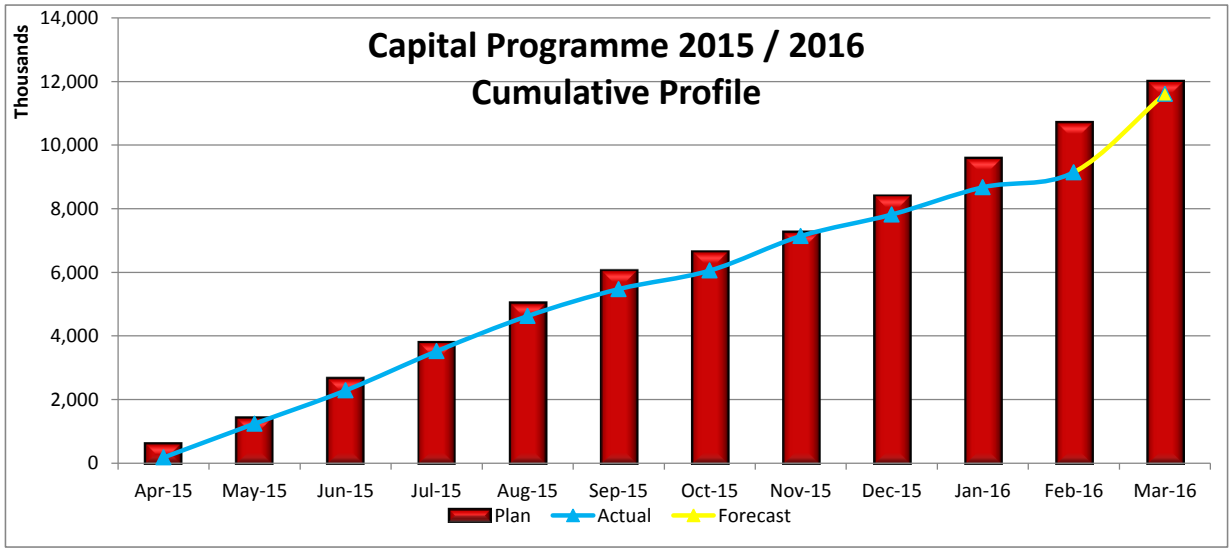
4. Creditors remain lower than planned but have increased again in month. This is a timing issue as approval for invoices are chased and we expect to reduce this value prior to year end.

5. Overall NHS accruals remain low, with the exception of 1 SLA with a Local Trust c £1.1m for the year to date. A resolution has been reached and payments are to be made in March 2016.

6. This reserve represents year to date surplus plus reserves brought forward.

# Capital Programme 2015 / 2016

| | Annual Budget £k | Year to Date Plan £k | Year to Date Actual £k | Year to Date Variance £k | Forecast Actual £k | Forecast Variance £k | Note |
|---|---|---|---|---|---|---|---|
| **Maintenance (Minor) Capital** | | | | | | | |
| Facilities & Small Schemes | 2,200 | 1,795 | 1,911 | 115 | 2,417 | 217 | 4 |
| IM&T | 2,348 | 1,970 | 435 | (1,535) | 1,754 | (594) | 3 |
| **Total Minor Capital & IM &T** | **4,548** | **3,765** | **2,346** | **(1,420)** | **4,171** | **(377)** | |
| **Major Capital Schemes** | | | | | | | |
| Barnsley Hub | 950 | 950 | 1,201 | 251 | 1,201 | 251 | 5 |
| Halifax Hub | 4,052 | 4,052 | 4,250 | 198 | 4,147 | 95 | 5 |
| Hub Development | 1,450 | 1,100 | 950 | (150) | 1,541 | 91 | 6 |
| Fieldhead Development | 1,000 | 850 | 493 | (357) | 552 | (448) | 7 |
| **Total Major Schemes** | **7,452** | **6,952** | **6,894** | **(58)** | **7,441** | **(11)** | |
| VAT Refunds | 0 | 0 | (93) | (93) | 0 | 0 | |
| **TOTALS** | **12,000** | **10,717** | **9,147** | **(1,571)** | **11,613** | **(387)** | |




**Capital Expenditure 2015 / 2016**

1. The Trust Capital Programme for 2015 / 2016 is £12.0m and schemes are guided by the overall Trust Estates Strategy.

A revised forecast expenditure of £11.5m has been communicated to Monitor; this specifically related to reduced IM & T expenditure following reduced costs from a competitive tendering process.

2. The year to date position is £1.57m under plan (15%). This is primarily within IM & T expenditure. The current full year forecast is £11.61m.

3. IM & T expenditure is behind the original expenditure profile but all relevant orders have been placed and are due to be received prior to 31st March 2016.

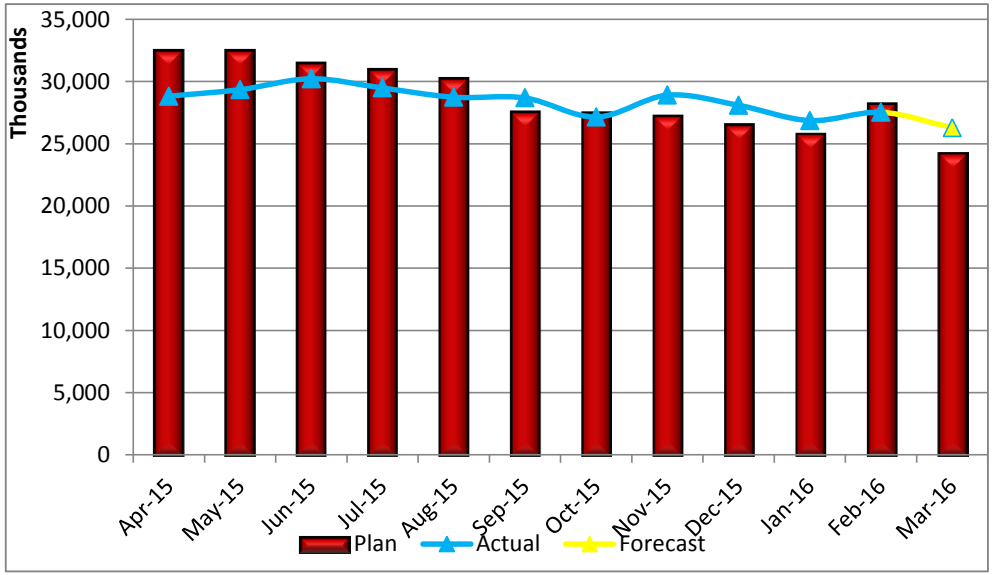
4 .The Minor Works programme is coming to an end with a slightly higher forecast outturn due to additional schemes delivered in year. This includes the Bretton Centre scheme which has now commenced.

5. Both the Barnsley and Halifax Hubs have been completed in year.Final invoices are awaited to confirm final values.

6. Progress continues on the Wakefield and Pontefract hubs; completion programmed for 2016 / 2017.

7. Work continues on developing the Fieldhead Non Secure proposal with GMP expected in May 2016. The Trust Annual Plan will reflect the latest profile we are working with our Partner to refine.

# Cash Flow & Cash Flow Forecast 2015 / 2016




| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 32,617 | 32,617 | |
| Closing Balance | 28,243 | 27,532 | (711) |

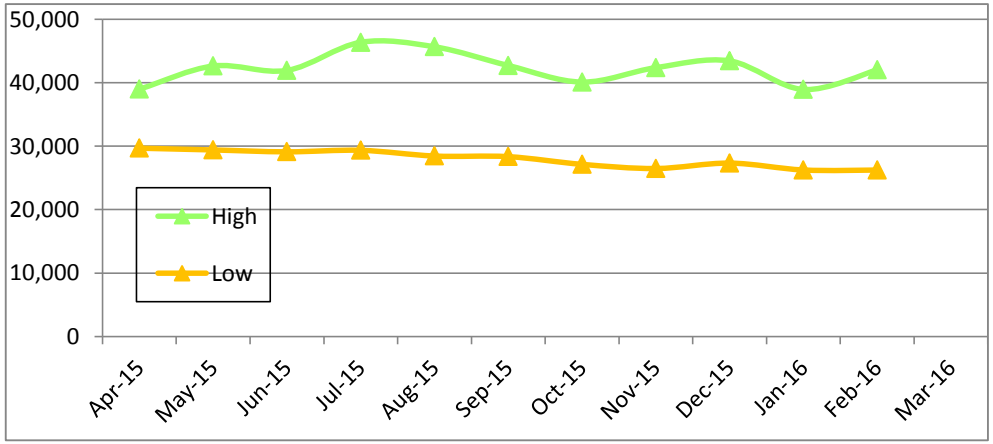
The Cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

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

Overall the cash position is £27.53m which is £0.71m lower than planned. This is primarily due to the timing delay in the sale of a Trust asset (£2.7m).

A detailed reconciliation of working capital compared to plan is presented at page 11.

Due to changes in the interest rates offered, the Trust is utilising the National Loans Fund scheme to invest £10m cash (until March 2016). This remains low risk investment but will attract improved rates of interest. (0.46%)



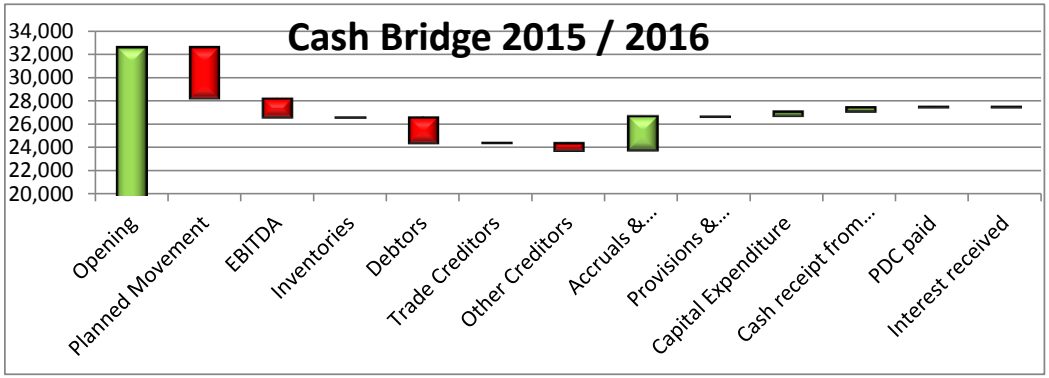

The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is: £42.04m
The lowest balance is: £26.24m

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

# Reconciliation of Cashflow to Cashflow Plan

| | Plan £k | Actual £k | Variance £k | Note |
|---|---|---|---|---|
| **Opening Balances** | **32,617** | **32,617** | | |
| Surplus (Exc. non-cash items & revaluation) | 8,046 | 6,457 | (1,589) | 1 |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | 0 | 0 | |
| Receivables (Debtors) | 1,000 | (1,219) | (2,219) | 4 |
| Trade Payables (Creditors) | 0 | 3 | 3 | |
| Other Payables (Creditors) | 0 | (621) | (621) | |
| Accruals & Deferred income | (1,500) | 1,398 | 2,898 | 2 |
| Provisions & Liabilities | (682) | (683) | (1) | |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (9,767) | (9,363) | 404 | 3 |
| Cash receipts from asset sales | 0 | 389 | 389 | |
| PDC Dividends paid | (1,540) | (1,516) | 24 | |
| PDC Received | 0 | | 0 | |
| Interest (paid)/ received | 69 | 70 | 1 | |
| **Closing Balances** | **28,243** | **27,532** | **(711)** | |




The Plan value reflects the May 2015 submission to Monitor.

Factors which increase the cash positon against plan:

1. EBITDA, in February 2016 is lower than planned for the first time in year. This is primarily due to the sale of a Trust Asset which is now expected in March 2016.
2. As noted within the Balance Sheet position accruals remain higher than planned. This gives the Trust a cash benefit as we have yet to receive and pay expected invoices.

3. Due to changes in the capital programme both Capital Expenditure and Capital Creditors are now beind plan. Spend will continue, especially for IM & T, so it is expected that this variance will reduce.

Factors which decrease the cash position against plan:

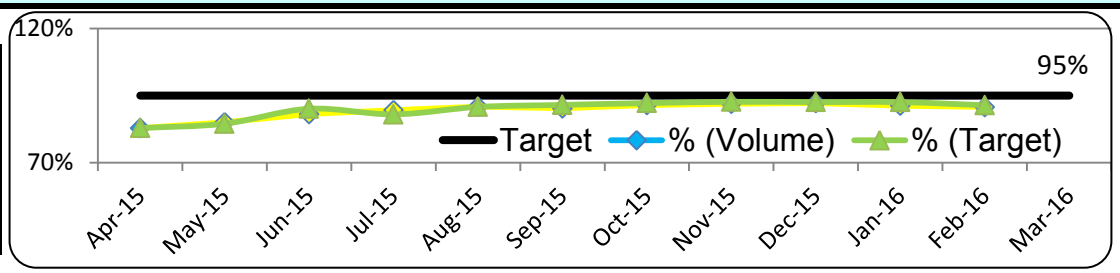
4 . Debtor levels overall are higher than planned. At month 11 both NHS and Non NHS debtors have increased. These are being targetted prior to year end to minimise the level of debt outstanding.

The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

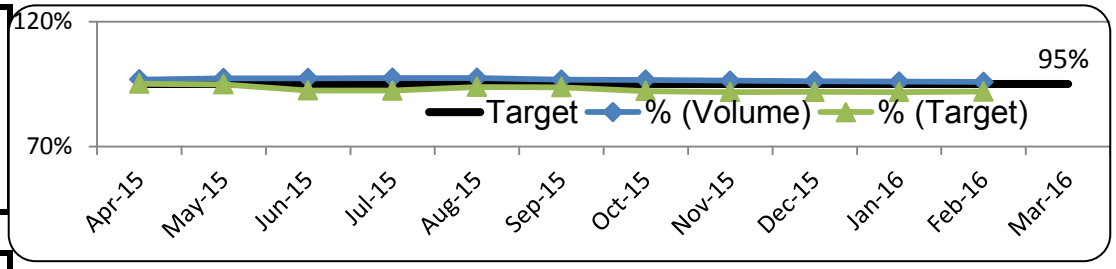
# Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code , payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delviery of the 95% target and identify solutions to problems and bottlenecks in the process.

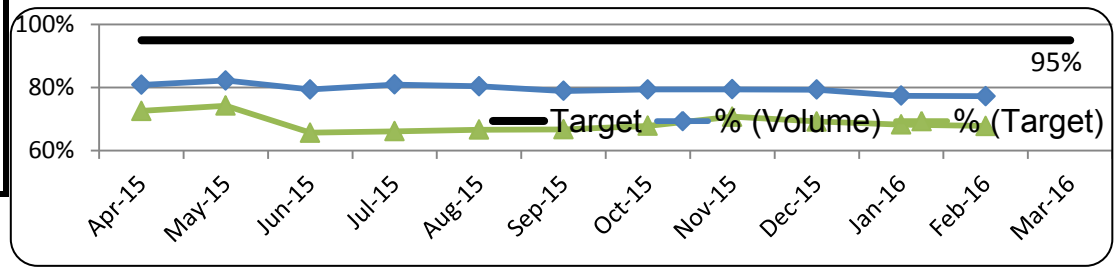
| NHS | Number % | Value % |
|---|---|---|
| Year to January 2016 | 91% | 93% |
| Year to February 2016 | 91% | 91% |




| Non NHS | Number % | Value % |
|---|---|---|
| Year to January 2016 | 96% | 92% |
| Year to February 2016 | 96% | 92% |




| Local Suppliers (10 days) | Number % | Value % |
|---|---|---|
| Year to January 2016 | 77% | 68% |
| Year to February 2016 | 77% | 68% |



# Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, central government expenditure over £25,000.

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

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

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

| Date | Expense Type | Expense Area | Supplier | Transaction Number | Amount (£) |
|---|---|---|---|---|---|
| 01/02/2016 | Rates | Kirklees | Kirklees Council | 2196553 | 451,666 |
| 15/02/2016 | Availability Charge SLA | Calderdale | Calderdale and Huddersfield NHS Fou | 8151394 | 208,399 |
| 25/01/2016 | Drugs FP10´s | Trustwide | NHSBSA Prescription Pricing Division | 2195476 | 97,340 |
| 03/02/2016 | Specialty Registrar (CT1-3) | Trustwide | Leeds and York Partnership NHS FT | 2196165 | 52,329 |
| 13/01/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2195064 | 51,508 |
| 13/01/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2195064 | 40,811 |
| 15/01/2016 | Staff Recharge | Wakefield | Wakefield MDC | 2195206 | 37,416 |

# Glossary

* Recurrent - action or decision that has a continuing financial effect

* Non-Recurrent - action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus the Board said it wanted to achieve for the year ( including non-recurrent actions ), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to achieve breakeven.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not pat of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. This Trust has historically only approved recurrent CIP's. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 7.3(i)

| | |
|---|---|
| **Title:** | **Safer staffing update** |
| **Paper prepared by:** | Director of Nursing, Clinical Governance and Safety |
| **Purpose:** | This paper builds on the previous papers submitted since July 2014. It outlines the continuing work being done to ensure ward areas provide staffing levels that are safe and effective. |
| **Mission/values:** | Honest, open and transparent, person first and in the centre and improve and be outstanding |
| **Any background papers/ previously considered by:** | Monthly safer staffing exception reports are submitted to the Trust Safer Staffing Group, the Executive Management Team and Deputy District Directors |
| **Executive summary:** | The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing.<br><br>At a national level, there continues to be key changes around the delivery of this agenda and, despite the lead on Safer Staffing having changed to NHS Improvement, there has been no definitive publication of Safer Staffing guidance for in-patient mental health/learning disability wards.<br><br>The Trust currently meets its safer staffing requirement overall although the planned levels of qualified (registered) staff are not always met. This results in use of existing staff doing additional hours, and of bank and agency staff, which the Trust aims to reduce. Planned in-patient staffing numbers rostered onto shifts meet or exceed the requirements for minimum staffing; however, staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is required to respond to fluctuations in need and demand.<br><br>In order to maintain progress, the Trust will:<br><br>1. continue to build on and improve data in exception reports including the development of dashboards for Datix incidents and triangulation of DATIX, exception reporting and HR information;<br>2. extend and maximise functionality within the current e-rostering system;<br>3. continue to provide effective and efficient support to meet establishment templates;<br>4. ensure project management arrangements are in place to work closely with areas where there are pressures in meeting staffing numbers.<br>5. update and revise safer staffing business case;<br>6. continue the safer staffing group, which will manage the supplementary staff project and monitor safer staffing issues, including a co-ordinated approach to recruitment, e-rostering, implementation of national staffing frameworks, monitoring use of agency staff, finance and related workforce issues, and will include staff side representatives;<br>7. identify a safer staffing lead to work with practice governance coaches to review safer staffing in the community and improve understanding and monitoring of direct care contact time. |
| **Recommendation:** | **Trust Board is asked to RECEIVE the report as assurance that the organisation is meeting safer staffing requirements.** |

| | |
|---|---|
| **Private session:** | Not applicable |

**Trust Board 29 March 2016**
**Safer Staffing Report**

## Introduction

This paper builds upon the previous Safer Staffing board reports submitted in July 2014, February 2015 and September 2015. It outlines the continuing work being done to ensure ward areas provide staffing levels that are safe and effective.

At a national level, there continues to be key changes around the delivery of this agenda. Despite the lead on Safer Staffing having changed to NHS Improvement there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health wards.

The most recent information has been the publication of the work NICE had completed on four areas prior to the suspension of the work in mid-2015. This was published in January 2016 following several Freedom of Information requests. Those areas considered were inpatient mental health settings, adult nursing care in community settings, accident & emergency and management & organisational approaches, which support safe staffing in nursing & midwifery. The Safe Staffing Levels (Wales) bill, which may have an impact on levels of staffing in the rest of the country, is currently passing through the Welsh assembly. However; this again concentrates on Acute General Health with a commitment to look at other areas in the future.

Given that any published tool lacks a local understanding or narrative at present we continue to utilise the decision support tool adapted previously for our trust to look at establishments on our ward areas.

We do, as per the CNOs letter dated February 2015, continue to maintain accurate and up-to-date information of "composite indicators" on ESR in relation to the proposed Safer Staffing Indicators:

1. Staff sickness rate, taken from the EST (published by HSCIC);
   Inpatient areas – 6.8% compared to the trust figure of 5.2%

2. The proportion of mandatory training completed, taken from the National staff survey measure;
   Inpatient areas: attendance 86.2% overall

3. Completion of a Performance Development Review (PDR) in the last 12 months, taken from the National staff survey measure;
   Inpatient areas – 95% completed (target 95%)

4. Staff views on staffing, taken from the 2015 National staff survey measure;
   Key Finding 14. Staff satisfaction with resourcing and support show a trust score of 3.42 from 5, which is above the national average for combined MH/LD and Community trusts.

Within SWYPFT, significant financial investments of £954,153k have already been made since 2014 to increase ward establishments and a crisis team in support of the safer staffing agenda. The Trust spend in excess of £4.7m on additional ward staff in the calendar year 2015 to meet demands arising from staffing shortfalls and/or increased clinical needs and risks.

## Summary of previous report and actions

In the previous Board assurance reports we identified a need for the following.

1. *Continue monitoring safer staffing returns and where necessary identify remedial actions to ensure adequate staffing levels.*

**Action**

Monthly exception reports now highlight areas where staffing levels fall below 90% overall and 80% registered-qualified staff. Ward managers in areas that fail to meet targets are asked to provide updates to help improve our understanding of why we have shortfalls. This "exception reporting" system continues to be developed to add more qualitative and quantitative data and now includes narrative from ward managers on why there were shortfalls, how they were managed and what action is being taken to prevent reoccurrence. Numbers of Datix incidents on staffing levels are included by BDU and data spanning the previous six months so any trends/themes can be identified.

This also includes going into areas that have specific challenges and providing a review of actions taken and recommendations to support staffing levels.

2. *Review safer staffing tool and pilot further in ward areas.*

**Action**

To date the staffing tool was used in May 2015 and showed that the majority of inpatient ward areas were staffed beyond the "minimum" levels informed by the tool. Due to changes within the trends of ward acuity, recruitment and retention this work will be revisited in the next quarter.

3. *Identify financial costs of current ward-based workforce across the Trust and calculate cost of meeting any staffing shortfall.*

**Action**

This was completed as part of the business case supporting the development of a peripatetic workforce. It continues to be analysed on a monthly basis.

4. *Continued establishment of the safer staffing group that includes nursing, HR, staff bank, finance and operational delivery staff to:*

**Action**

We are updating the development plan for the peripatetic workforce as part of the overall supplementary workforce agenda.

A systematic review of the Staff bank will be completed with a view to centralising it to support areas in recruiting into their staffing shortfalls as efficiently and effectively as possible.

## Analysis of fill rates August 2015 – February 2016

The Deputy District Directors and EMT receives monthly exception reports on areas where fill rate overall (registered nurses and nursing support) is below 90%, and where registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rate not achieved, how it was managed and actions to prevent recurrence.

**All Shifts Fill Rate in past six months – Day and Night Shifts** (%)

| | Aug | Sept | Oct | Nov | Dec | Jan | Average |
|---|---|---|---|---|---|---|---|
| **Average** | **102.7** | **103** | **106.6** | **106.1** | **104.6** | **105.6** | **104.8** |

Registered Nurse Fill Rate – **Day Shifts ONLY** (%)

| | Aug | Sept | Oct | Nov | Dec | Jan | Average |
|---|---|---|---|---|---|---|---|
| **Average** | **88.6** | **90.2** | **94.9** | **97** | **92.2** | **90.9** | **92.3** |

Registered Nurse Fill Rate – **Night Shifts ONLY** (%)

| | Aug | Sept | Oct | Nov | Dec | Jan | Average |
|---|---|---|---|---|---|---|---|
| **Average** | **95.2** | **97.4** | **97.6** | **98.8** | **96.8** | **98.9** | **97.4** |

Overall

This shows a minimal improvement in overall fill rate as well as days only RNs however a significant improvement of 2.4% on nights RNs should be noted.

Forensic BDU continues to experience most issues with staffing levels but managers have provided helpful exception reports on how issues are being managed. Bronte (PICU) in particular has seen a consistent challenge in fill rates for registered staff on both days and nights. However, staff numbers have been uplifted with the use of non-registered coverage whilst utilising registered support across the unit as required. Units engaged in the transformation project (in particular Substance Misuse Unit and Castle Lodge) have struggled to stay within fill rates. Going forward this will no longer influence the figures and give a slightly distorted picture in two areas. Trinity 2 continues to experience difficulties in meeting registered fill rates in nights due primarily to vacancies and Elmdale will achieve the target fill rates more readily after changing back to having 3 registered staff on nights.

**Analysis of Datix incidents related to staffing**.

In the 12 months up to 29th February 2016, there were 230 Datix incident reports highlighting staff shortages. Although this is a reduction in the number of reported incidents and continues to equate to less than one Datix incident per 100 shifts, it is important that the Trust triangulate Datix information with safer staffing fill rates and exception reporting to ensure safer staffing is maintained and this is taking place in the Safer Staffing Group.

**Review of Impact on Quality Following Introduction of 12 Hour Shift Pattern**

This was undertaken and reported (April 15). In relation to its impact upon staffing the review will be repeated later this year when more data qualitative data will be available. In summary, data at 12 months review showed an increase in mandatory training attendance, increased staffing fill rates, more opportunity for staff to take their breaks and slight reduction in sickness levels. However, use of bank staff decreased while use of agency increased and turnover of staff increased, although this was across all wards and not just in wards that changed to 12 hour shifts.

**Peripatetic staffing case**

Safer Staffing Project Manager commenced in post in January 2016. As part of the development of a supplementary workforce, a peripatetic workforce will be developed to enhance flexibility and sustainability of the workforce and giving more opportunities to cover the shortfalls as they arise. The business case approved by EMT in August 2015 is currently being updated to take account of changes in staffing required, a higher than expected vacancy rate and increased use of agency staff.

**Summary and next steps**

The national commitment to safer staffing is ongoing and SWYPT need to maintain the progress already made in delivering safer staffing. The Trust currently meets its safer staffing requirement overall although there is regularly a shortfall in qualified staff and some areas have difficulty finding sufficient staff at times of increased demands. This results in use of existing, bank and agency staff and increases risks due to variable quality and competencies of staff and lack of familiarity with the Trust.

Planned inpatient staffing numbers rostered onto shifts meet or exceed the requirements for minimum staffing. However, staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is

required to respond to fluctuations in need and demand. The proposed peripatetic workforce supported by an enhanced centralised bank staff management system is likely to result in financial savings while providing higher quality staffing and safer care for service users.
Current plans will help the Trust prepare for new guidance from the centre and also provide the Trust with the capacity and a platform from which to explore further workforce initiatives around the quality of care contact time, multi-professional approaches and use of non-registered staff. Future plans include;

1. Continue to build upon and improve data in exception reports including
    - develop dashboards for Datix incidents
    - triangulation of DATIX, exception reporting and HR information
2. Extend and maximise functionality within current e-rostering system.
3. Continue to provide effective and efficient support to meet establishment templates.
4. Project manager to work closely with 'hotspot' wards where pressure on meeting staffing numbers.
5. Update and revise safer staffing business case
6. Continue safer staffing group who will manage the supplementary staff project and monitor safer staffing issues including a co-ordinated approach to recruitment, e-rostering, implementation of national staffing frameworks, monitoring use of agency staff, finance and related workforce issues. This will include staff side representatives.
7. Safer staffing lead to work with PGCs to review safer staffing in the community and improve understanding and monitoring of direct care contact time.

**Appendix 1**

**Board Checklist**

1. Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?
   Board receives regular presentations on staffing (e.g. monthly exception reports Regular assurance visits from Board members to the wards/departments in order to learn about and understand the services better (e.g. CQC mock visits)

2. Are their processes for escalating issues identified by staff, patients or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services?
   Acuity is regularly and routinely monitored on wards including need for 1:1 observations. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system.

3. Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence based approach? How can the calculator tools be best deployed in delivering this?
   Trust has developed a bespoke decision support tool. The tool has been developed in collaboration with ward managers as a decision support tool, to enable staff to match bed numbers with other variables, such as acuity, and calculate the numbers of staff and skill mix required to run both a day and night shift given these circumstances. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.

4. What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?
   Managers are empowered to use a range of interventions (e.g. use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement.

5. How are the needs of Mental Health service users incorporated in staffing?
   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.

6. What evidence is there that a multi-professional approach to staffing is being deployed across the organisations? How is the need to spend time simply engaging with and talking to the patients built into workload calculation?
   Transformation programme currently underway considers how care pathways can be enhanced by all professional groups. Service user and carer engagement and satisfaction tools assure us that service users and carers are largely satisfied with the care and treatment they receive.

7. As well as staffing measures outlined by the NQB are there measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?
   Complex benchmarking and performance data is widely available throughout the organisation and drills down to team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.

8. How might this ward staffing information be presented differently within a Mental Health setting where the ward based team is not the only important resource available?
   Wards display boards which demonstrate staffing fill rates. More work to support better information to the public about the wider MDT may be required.

9. How are the challenges of filling specific Mental Health roles handled? E.g. recruitment training etc.?
   We have extremely good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. Training Needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.

10. How is the commissioner kept informed about best practice in Mental Health such that informed commissioning decisions are made?
    Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 7.3(ii)

| | |
|---|---|
| **Title:** | **Information governance position statement** |
| **Paper prepared by:** | Deputy Chief Executive |
| **Purpose:** | To advise Trust Board of the Trust's position in relation to information governance at March 2016. |
| **Mission/values:** | Information governance is a key issue for patient safety. Information Governance Toolkit Compliance at Level 2 across all 45 requirements is currently a requirement to remain IG Statement of Compliance (IGSoC) compliant. |
| **Any background papers/ previously considered by:** | Information governance updates have been provided to the Clinical Governance and Clinical Safety Committee and the Executive Management Team approved the Information Governance, Information Sharing, Confidentiality and Data Protection, and Safehaven policies in March 2016. |
| **Executive summary:** | **Outcome of information governance toolkit and internal audit review**<br>The Information Governance self-assessed scores are submitted annually. This paper updates Trust Board on the Trust position in relation to information governance by providing a summary of the scores and details of information governance serious incidents requiring investigation (SIRIs), which have occurred during the year. The scores are provisional at this time. Each of the 45 standards has four possible levels of achievement (0, 1, 2 and 3). Trusts are expected to achieve at least level 2 on each standard.<br>The information governance management area includes the Trust's highest risk area, its staff achievement of the target of 95% of all staff completing information governance training annually. The Trust position at 11 March 2016 is 95.1%. Approximately 300 staff are excluded from the figures due to maternity leave, long-term sickness, etc.<br>The Information Governance Toolkit (IGTK) is required to be independently audited annually. KPMG, as the Trust's internal auditor, has been commissioned to conduct the audit and is preparing the final report of ten standards that have been independently audited. It is expected that eleven of the twelve recommendations made will now be agreed as 'implemented' and one which will be classed as 'partially implemented'. This is a low level risk with regard to external training for the Caldicott Guardian. The Caldicott Guardian is appropriately trained to NHS Standards and has completed refresher training with the Health and Social Care Information Centre (HSCIC) e-learning module; however, due to availability of external courses, there will be a period of approximately six weeks before the external refresher course can be completed. This will not impact on achieving a Level 2 with any Caldicott standards on the IGTK and is purely one of the recommendations from the audit report.<br><br>The IGTK is appropriately evidenced and scored at Level 2 across all required standards. This year's version 13 IGTK for 2015/16 is ready for submission on 24 March 2016 as follows, subject to KPMG's final opinion. |

| Assessment | Level 0 | Level 1 | Level 2 | Level 3 | Not Relevant | Total Req'ts | Overall Score | Initial Grade | Current Grade |
|---|---|---|---|---|---|---|---|---|---|
| Version 13 (2015-2016) | 0 | 0 | 44 | 0 | 1 | 45 | 66% | Satisfactory | Satisfactory |

Director leads

The Deputy Chief Executive is the Trust SIRO (Senior Information Risk Owner) and IG director lead. The Director of Nursing is the Trust Caldicott Guardian and the lead director of clinical records. The Director of Corporate Development is the lead director for non-clinical records.

**Incidents**

Guidance is issued annually by HSCIC requiring Trusts to report any incidents scoring level 2 or above externally to HSCIC and the Information Commissioners Office (ICO). The scoring criteria takes into account the number of people affected but also the type of incident and the sensitivity of the information. As such, one letter with sensitive information wrongly addressed may be a level 2 score as is the case with the incidents being investigated below. A new method of scoring was implemented in 2013 by the HSCIC. This meant that incidents which previously would not have been reported are now required be reported externally. The new scoring method means that the misdirection or loss of one person's clinical information, where it relates to mental health, or children, or a sensitive condition may meet the criteria to be reported externally.

At the current time, three incidents have been reported as meeting the threshold for external reporting under the new reporting requirements during 2015/16. One incident relates to a release of information without the consent of the individual (November 2015). One incident was classified as a Cyber SIRI (August 2015) and one incident relates to incorrectly addressed mail (January 2016). The latest incident is being followed up by the ICO and could result in enforcement action or a fine.

**Undertaking to Information Commissioner**

The Chief Executive signed an undertaking to the Information Commissioner's Office (ICO) on 22 May 2015, which was issued following a series of SIRI incidents reported during 2014/15. The ICO issued an action plan which the Trust has worked through in order to satisfy the requirements outlined. Evidence collated and submitted to the ICO was subject to a desk-based review, which was carried out in December 2015. This involved the ICO scrutinising the documented evidence provided to them to substantiate the actions and recommendations detailed within the action plan they provided with were being implemented. On completion of this process, the ICO noted the work which had been undertaken to mitigate against a reoccurrence of the incidents recorded. Several additional recommendations were made of which the only outstanding action is a review of the Investigating and Analysing Incidents, Feedback and Claims to Learn from Experience Policy to ensure SIRI incident learning is applied to this document.

In addition the Trust has committed to a voluntary data protection audit by the ICO, which will take place week commencing 28 November 2016. The remit of this audit will be agreed with the ICO in advance of the visit.

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| | **Cyber SIRI (Virus)**<br>The Trust reported a Cyber SIRI due to a virus incident on 27 August 2015. The incident caused a significant disruption of the Trust Information Technology infrastructure; however, no data was lost or compromised as a result of this incident. The virus was a day zero attack and the Trust's anti-virus supplier did not have a signature to detect and block the malicious software. The incident was dealt with by the Trust's IT provider, Daisy Group, and co-ordinated by the Trust's IT Service Management so as to ensure that remedial actions and control measures were put in place to address the detection of this specific virus. The IT industry remains, as a whole, susceptible to further day zero attacks, which are growing in number and sophistication over time. Cyber SIRI reporting criteria were introduced into the current IG Toolkit with onward dissemination to the ICO.<br><br>**RiO version 7**<br>The RiO clinical information system was upgraded during the week commencing 23 November 2015. Following the upgrade process, the Trust has suffered a significant number of system functionality and hardware configuration issues, which have resulted in disruption to the delivery, performance and accessibility of the application to clinical staff. The majority of issues identified have been resolved directly or via work around processes and the Trust continues to work with the system supplier to address all remaining issues identified to Trust satisfaction. The situation has led to the Trust escalating the issues to the system supplier's executive management team.<br><br>The IG implications in respect of this were:<br>- staff were unable to access the clinical record to add or update data;<br>- active users were disconnected from the application without warning;<br>- clinical data was not saved despite appearing to have been saved; and<br>- application functionality did not work as intended resulting in error messages and lack of access to key areas of the system.<br><br>The Trust has conducted an internal investigation in respect of this upgrade.<br><br>**Future plans**<br>The Trust's external auditor, Deloitte, will be commissioned by the Director of Corporate Development to undertake an external independent review of the RiO version 7 implementation, the scope and scale of which are currently being decided upon.<br><br>The Information Governance agenda for 2016/17 will focus on the revised IG Toolkit, which is scheduled for release in June 2016. The focus of the IG team will be to review common patterns across previously and newly recorded incidents to assist the Trust in reducing the total number of incidents.<br><br>In addition, the General Data Protection Regulation (GDPR) is a regulation currently under development by which the European Commission intends to strengthen and unify data protection for individuals within the European Union. It is expected that this legislation will be introduced in 2016 with full implementation by 2018, which will in turn influence the IG agenda. |

As noted, a voluntary data protection audit by the ICO which will take place week commencing 28 November 2016

Key areas of concern remain and there is more work to be done around the number of incidents being recorded by staff. The table below summarises IG incidents logged by BDUs over the past twelve months and demonstrates an overall downward trend. The IG team will continue to deliver training, advice and support across the organisation and work to deliver the 'THINK IG' branding and associated messages to all staff.

| **BDU** | ***Q4 2014/15*** | ***Q1 2015/6*** | ***Q2 2015/6*** | ***Q3 2015/6*** |
|---|---|---|---|---|
| Barnsley | *40* | *53* | *26* | *13* |
| Wakefield | *11* | *10* | *10* | *3* |
| Calderdale | *4* | *8* | *5* | *10* |
| Forensic | *6* | *6* | *6* | *4* |
| Kirklees | *13* | *5* | *8* | *13* |
| Specialist services | *20* | *18* | *24* | *16* |
| Corporate | *9* | *4* | *7* | *3* |
| **Total** | ***103*** | ***104*** | ***86*** | ***62*** |

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| **Recommendation:** | **Trust Board is asked to NOTE the current position regarding information governance and to APPROVE the Trust's information governance toolkit submission.** |
| **Private session:** | Not applicable |

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South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 7.3(iii)

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| **Title:** | **Eliminating mixed sex accommodation declaration of compliance** |
| **Paper prepared by:** | Director of Nursing, Clinical Governance and Safety |
| **Purpose:** | To appraise Trust Board of the Trust position in relation to eliminating mixes sex accommodation (EMSA) and to approve the annual declaration. |
| **Mission/values:** | Safeguarding the privacy and dignity of service users when they are often at their most vulnerable. |
| **Any background papers/ previously considered by:** | Trust Board reviews the compliance statement on an annual basis. Any exception reports regarding EMSA are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing. There have been no exception reports in 2015. |
| **Executive summary:** | **Background**<br><br>This paper is intended to assure Trust Board of the organisation's level of compliance with the national standard in respect of eliminating mixed sex accommodation. The declaration of compliance, which will appear on the Trust's website, is shown below. The Trust is expected to make a declaration to commissioners by 31 March 2016 to confirm the Trust's position regarding compliance with the EMSA standard. The statement of compliance is then required to be posted on the Trust website.<br><br>The guidance in relation to EMSA expects Trusts to provide the following accommodation. Single Sex accommodation can be provided in:<br>• single sex wards (the whole ward is occupied by men or women but not both);<br>• single rooms with adjacent single sex toilet and washing facilities;<br>• single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room.<br><br>In addition, service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own.<br><br>**Current Trust position**<br>During 2015/16, there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows.<br><br>*"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.*<br><br>*"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same* |

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| | *sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."*<br><br>**Compliance monitoring**<br>The Clinical Governance and Clinical Safety Committee receives assurance through the Director of Nursing about the Trust's compliance with eliminating mixed sex accommodation. Any potential areas of risk are considered at quarterly EMSA review group meetings. During 2015, the EMSA review group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2015, there were 21 such instances reported on Datix compared with 22 for the same time period in 2014. The 2015 EMSA Best Practice Guidance Audit Report indicates that the Trust continues to perform well against best practice standards. The EMSA review group will implement action against any areas where improvements can be made. The Trust also has an action plan for continued monitoring and improvement, which is linked to the Patient-led Assessment of the Care Environment (PLACE). Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made.<br><br>**Financial implications**<br>Non-compliance against the eliminating mixed sex accommodation standard is a 'nationally specified event'. An EMSA breach will continue to carry financial penalties.<br><br>**Legal implications**<br>The Trust will need to ensure that it is compliant with safeguarding issues related to the provision of services through safe delivery of the Department of Health guidance on eliminating mixed sex accommodation.<br><br>**Equality and diversity**<br>The Trust's statutory duties relating to equality and diversity have been met. The Trust has considered equality and diversity when developing its estate to meet the privacy and dignity needs of service users. |
| **Recommendation:** | **Trust Board is asked to APPROVE the compliance declaration.** |
| **Private session:** | Not applicable |

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South West Yorkshire Partnership NHS
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# Trust Board 29 March 2016
# Agenda item 8.1

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| **Title:** | **Annual Governance Statement 2015/16** |
| **Paper prepared by:** | Chief Executive |
| **Purpose:** | The purpose of the paper is to seek Trust Board support for the first draft of the Annual Governance Statement, which will be included in the annual report and accounts for 2015/16 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 :<br>- scope of responsibility;<br>- the purpose of the system of internal control;<br>- capacity to handle risk;<br>- the risk and control framework;<br>- review of economy, efficiency and effectiveness of the use of resources;<br>- annual Quality Report;<br>- review of effectiveness;<br>- conclusion.<br>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 2015/16.<br>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 2015/16.<br>The AGS has been produced in accordance with current guidance from Monitor. The Trust is required to include the narrative in orange in the Statement by Monitor as this follows HM Treasury guidance. |
| **Recommendation:** | **Trust Board is asked to APPROVE the first draft of the Annual Governance Statement for 2015/16.** Trust Board should note that the Statement will 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** |

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| | **a final version of the Statement as part of its approval of the annual report and accounts on 24 May 2016.** The final version of the statement will be brought back to Trust Board in June 2016 as part of Trust Board's consideration of the annual report and accounts. |
| **Private session:** | Not applicable |

# Annual Governance Statement 2015/16

## 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 and demonstrates the complexity and diversity of the services the Trust provides and the geographical areas it covers. This presents a unique challenge for the Trust, which is reflected in its 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 2016 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 and one of the principal strengths for the Trust in this regard has been the stability of its Board. This year has proved to be one of considerable change, both for Non-Executive and Executive Directors.

In my Statement for 2014/15, I commented on the challenge in terms of changes to Non-Executive Directors on the Board in the coming year as two experienced and long-standing Non-Executive Directors would come to the end of their terms of office during 2015. 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, was to ensure effective succession planning with minimum disruption to the stability of the Board. As a result, the Committee sought to appoint two individuals with the skills and experience to ensure the Board retained the skill-set of departing Non-Executive Directors.

Given the calibre of the candidates interviewed, the Nominations Committee approved a recommendation from the interview panel to appoint three candidates as it was considered that all would bring something different and add value to the Board, which was thought to be particularly appropriate given the challenge and volume of work currently for Non-Executive Directors. The Members' Council approved the appointments and the new Non-Executive

Directors joined the Trust on 1 May, 1 August and 1 October 2015. There has been a successful and smooth, which has minimised any risk to the organisation.

Given the significant change to the membership of the Board, the Members' Council also approved the re-appointment of one non-executive director, who had already served two terms of office, for a further year to continue to provide stability and strength within the Board.

Following the Chief Executive's decision to take voluntary early retirement on 31 March 2016, the Chair instigated a robust and challenging recruitment process for a successor who would continue to drive the Trust forward as the values-based organisation it has become. This culminated in the appointment of Rob Webster who will join the Trust from his role as Chief Executive of the NHS Confederation from 16 May 2016. In the interim, the Deputy Chief Executive will act as Chief Executive with appropriate cover arrangements in place.

During the year, the Remuneration and Terms of Service Committee also considered a proposal to split the role of Deputy Chief Executive/Director of Finance as, in the current challenging times both internally and externally, the planning, contracting and commercial aspects of the Deputy Chief Executive role were becoming increasingly important and demanding in terms of capacity and involvement, which could, potentially, have an adverse impact on the finance function. An interim Director of Finance was appointed on 4 January 2016 and a recruitment process begun, which resulted in the appointed of XXXX from XXX who will join the Trust on XXXX.

This year also saw the decision of the Deputy Chief Executive to seek early retirement from the Trust at the end of May 2016. This will obviously present a risk to the Trust in terms of stability and continuity at Chief Executive level; however, I am confident that the remaining members of the Executive Management Team have the skills and experience to mitigate and robustly address any risk to the Trust.

During the year, the changes I 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. Deputy directors are now in place across all Business Delivery Units (BDUs) providing operational leadership and management. This allows BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. This year also saw the embedding of arrangements at service line level to provide the leadership and management 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 child and adolescent mental health (CAMHS) and forensic services, with the support of the Remuneration and Terms of Service Committee, I created a permanent post to cover forensic and specialist services at BDU Director level with an appointment from 21 March 2016. The interim management of CAMHS has provided focussed operational support at Director level to take forward the recovery plan agreed with commissioners in Calderdale and Kirklees. Trust Board has scrutinised implementation of the plan through the year and agreed in December 2015, given the progress the Trust had made in this area, for continued monitoring and assurance to be provided through the Clinical Governance and Clinical Safety Committee.

During the year, the Trust has also sought interim support at Director-level for engagement, marketing and commercial development.

Although I have adopted a prudent approach to Director-level appointments over the past year, in consultation with the Chair, the Trust continues to face a challenging and difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. To meet these challenges, the Trust Board structure will continue to 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.

The Trust continues to lay the foundations for its ambitious service change programme and to develop 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 the Trust remains sustainable and viable. Implementation of the programme as well as maintaining delivery of high quality and safe services has, again, presented the Trust with its biggest challenge in 2015/16. 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 change needed during the coming year.

The strategic framework for the organisation 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.

The articulation of 'How the Organisation Runs' sets out our mission and strategic objectives, clarifies the roles and responsibilities at every level of the organisation to deliver continued success, and 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, 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, communications, engagement and public involvement; and
- health intelligence and innovation.

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 and the development of a recovery approach and 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 for the benefit of people who use our services 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 2015/16 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 safeguarding boards, health and wellbeing boards, 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 Chair of the NHS Confederation Mental Health Network Board. The Trust Chair is a member of the NHS Providers Board, the trade body for NHS providers of services.

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 consult and 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.

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.

At the end of April 2015, Trust Board commissioned Deloitte to undertake an independent review of the Trust's governance arrangements using Monitor's well-led governance framework. Trust Board decided to undertake an independent review at this time as part of the developmental approach to its governance arrangements and to ensure fitness for purpose as the Trust moves to the next challenging phase. At the time, the Trust had not yet been scheduled for a full Care Quality Commission inspection. The outcome of the review was presented by Deloitte to Trust Board in July 2015 and formally presented at the public session of the Board in September 2015 and the Members' Council in November 2015. Deloitte also facilitated a joint session for Trust Board and the Members' Council to undertake further work on action in relation to the recommendations arising from the review.

There were no 'material governance concerns' arising from the review. Trust Board is not complacent, however, as there are a number of developmental areas where Deloitte recommended further work and these form the basis of an action plan with timescales, which Trust Board has taken forward. The process and outcome reflect the developmental approach taken and Trust Board is satisfied with the outcome. The most pleasing aspect for Trust Board was that the Deloitte report very much reflected its own assessment of the Trust's arrangements and the report provides a series of helpful and constructive recommendations.

The Trust was also subject to an inspection by the Care Quality Commission in March 2016. The inspection team visited all of the Trust's in-patient units, a third of community mental health teams and a cross-section of general community services. The overwhelming feedback from the inspection team chair was that our staff were found to be caring, and this was without exception. The Care Quality Commission was also impressed with how welcoming, helpful, open and honest the Trust and its staff were found to be, as well as how organised. Some notable areas of good practice were highlighted as:

- in general community services, this included the commitment of staff in Barnsley 0-19 service, telehealth and care navigation service, epilepsy service and end of life care service;
- in mental health and specialist services, this included attention deficit hyperactivity disorder service, prison in-reach, community learning disability service, community child and adolescent mental health service and older people's wards.

There were also some areas of concern, most of which the Trust is aware of and has mitigating action in place to address the issues. This included:

- safer staffing, particularly on acute wards;
- monitoring of care and treatment in rehabilitation services (mental health), particularly at Enfield Down;
- Mental Health Act and Mental Capacity Act training and recording of it taking place;
- waiting lists for child and adolescent mental health services and psychological therapies; and
- physical health monitoring.

The report will be sent to the Trust in May 2016 to check for factual accuracy with receipt of the formal report on or around 7 June 2016. This will be followed by a Quality Summit later in the summer.

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. 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 Trust 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 monitoring, 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 2016 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 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. The opportunity to share concerns and good practice is facilitated through BDU governance groups led by District Directors.

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

1. Risk of adverse impact on clinical, operational and financial risk if the Trust is unable to manage the transition in year 3 of the five-year plan as the plan states that the Trust would be operationally, clinically and financially unsustainable by the end of 2016/17 in its current configuration.
   Mitigated by active stakeholder management to create opportunities for partnership and collaboration, development of 'preferred partner' arrangements, robust monitoring by the Executive Management Team and Trust Board, recruitment to key areas of expertise to realise the five-year plan through health intelligence, marketing and commercial skills, increasing use of service line reporting to inform service decisions and increase in joint bids and projects to develop strategic partnerships.

2. Risk that the planning and implementation of transformational change through the transformation programme will increase clinical and reputational risk in in-year delivery, particularly through skills and capacity to balance the 'change job' and the 'day job'.
   Mitigated by staff engagement strategy in place with implementation plan, director objectives specifically linked to manage the risk, regular monitoring by the Executive

Management Team and Trust Board and a well-established quality impact assessment process in place.

3. Risk that the planning and implementation of transformational change through the transformation programme is not aligned to NHS and local authority commissioning intentions and will increase clinical, operational, financial and reputational risk through potential implementation of service models which are not supported by commissioners.
   Mitigated by development of an engagement plan with stakeholders, active participation in service integration initiatives across the Trust's districts, development of stronger links with national bodies to influence local and national agendas in relation to mental health, strengthening of the link between transformation and contracting and agreement of number of key transformation projects supported by commissioners and local authority Overview and Scrutiny.

4. Risk that the impact of continued reduction in local authority budgets may have a negative impact on the level of financial resources available to commission services from NHS providers, which represents a clinical, operational and financial risk, in particular for services commissioned by public health.
   Mitigated by monitoring through BDU/commissioner forums, and joint working and development of joint approaches with local authorities.

5. Risk that the Trust's clinical, operational and financial sustainability will be adversely affected in 2016/17 by the impact of local commissioning intentions from clinical commissioning groups and local authorities.
   Mitigated by proactive involvement in system transformation programmes, internal transformation programme linked to commissioning intentions, planned improvement in bid management processes and horizon scanning for new opportunities, increase in capacity and skills to support stakeholder engagement, maintain robust controls on costs to maximise contribution and alignment of commissioning intentions with strategic plan for 2016/17.

6. Risk that continued reduction in local authority funding and changes in the benefits system will result in an increased demand for health and social care services, which may impact on the capacity of Trust services.
   Mitigated by monitoring through BDU/commissioner forums, joint working and development of joint approaches with local authorities, and weekly risk scan by Director of Nursing and Medical Director.

7. Risk that implementation of new currency models moving current funding arrangements from block contracts to activity-based contracts may present clinical, operational and financial risk if cost and pricing mechanisms are not fully understood.
   Mitigated by inclusion of currency modelling in mental health transformation projects, contract agreements and monitoring in place with commissioners, monitoring at service line by 'trios' within services, and ongoing monitoring and scrutiny through the Executive Management Team, the Audit Committee and the Operational Requirement Group.

8. Risk that capture of clinical information on the Trust's clinical information system will be insufficient to meet future compliance and operational requirements to support service line reporting and implementation of mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.
   Mitigated by Systems Development Board in place led by Director of Nursing, additional resources allocated and managed by 'trios' within services, ongoing monitoring and scrutiny by Executive Management Team, Audit and Clinical Governance and Clinical Safety Committees, and action plan in place to address five priority areas.

9. Risk that bed occupancy above that expected as a result of increase in acuity and admissions is causing pressures across bed-based services across the Trust.
   Mitigated by bed management systems in place across all BDUs to manage patient flow, reduce out-of-area placements and reduce delayed discharges of care, weekly situation reports to assess the position at the Operational Requirement Group, internal audit undertaken on implementation of bed management protocol with action plan in place, and Trust-wide bed position available to all relevant staff to enable effective use of Trust bed-base.

10. Risk that upgrade to the Trust's clinical information system, RiO, which resulted in system functionality and operational issues, will impact on the Trust's ability to effectively support clinical services operationally, in the production and submission of central returns and accurate recording of clinical coding information.
    Mitigated by robust processes in place to review and monitor progress resolution at a senior level and to manage effective communications, daily contact with system supplier regarding issue resolution and progress, internal investigation complete with report to be presented to the Executive Management Team, external, independent review to be commissioned by Director of Corporate Development and weekly monitoring of issues at both Executive Management Team and Operational Requirement Group.

11. Risk that, in 2016/17, the Trust will be unable to secure sufficient funding to support a sustainable child and adolescent mental health service.
    Mitigated by the introduction of 'summit' meetings during 2015/16 involving local commissioner and local authority representation, review through regular contracting meetings and Quality Board, development of a robust recovery plan monitored by Trust Board and joint work in place with commissioners as part of 2016/17 contract negotiations.

12. Risk that the increase in reported information governance incidents to the Information Commissioner will impact on the Trust's reputation.
    Mitigated by additional action taken to review guidance and policies, targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents, awareness raising sessions in place at all levels in the organisation, re-branding of materials and advice for staff and increase in availability of training for staff.

The risks outlined above will continue into 2016/17 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 and risk 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. Practice Governance Coaches work

within BDUs to learn lessons, implement best practice and address areas of weakness and development.

The Trust works hard to provide 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 scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports, such as the Mazars report on Southern Health NHS Foundation Trust, the national audit of schizophrenia and the Lampard Report, 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 2015/16, there were XX serious incidents across the Trust compared to 106 in 2014/15. The underlying trend 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 Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact on 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.

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.

Early in 2015, Trust Board established an Equality and Inclusion Forum to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. The Forum develops and oversees a strategy to improve access, experience and outcomes for people from all backgrounds and communities including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

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 reinforces the organisational value of conducting the programme. Visit team findings facilitate learning and provide 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 are used to inform changes to the next planned visit programme. In preparation for its inspection visit in March 2016, the programme focused particularly on assessment against both the CQC essential standards and the Trust's quality priorities.

The Trust assesses itself annually against the NHS Constitution and a report was presented to Trust Board in September 2015. This covered all areas of the Trust. The Trust meets the rights and pledges of the NHS Constitution; however, there are elements of the Constitution that refer to consultation and involvement with service users. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be 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, 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 serious incidents, 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' across the Trust involving service users and carers, and stakeholders, including staff.
- Insight events for members and the public held twice a year.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's 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 holds the Cabinet Office's Customer Service Excellence award.

## 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, through 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 2015/16, work has continued to develop and strengthen 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 whilst aligning Trust plans with commissioning intentions and wider district plans. These annual plans detail the workforce and financial resources

required to deliver 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 Operational Requirement Group continues to meet weekly to support implementation of the 2015/16 plan and to ensure robust operational management is in place to manage Trust resources and to achieve the targets set out in the Trust's annual plan. The Group is attended by Executive and operational Directors and their Deputies and meets weekly, chaired by myself. The Group supports the assurance provided to the Executive Management Team 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 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 were 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 considered the risk to delivery to be higher.

I have again asked Deloitte to undertaken a review of the Trust's plan for 2016/17, the implementation of the plan for 2015/16 and the recommendations made. Deloitte will report to Trust Board at its April 2016 meeting.

During 2015, the arrangements for external and internal audit came to an end. For external audit, the Trust's contract with Deloitte came to an end on 30 September 2015. Following a robust and open procurement exercise against the national framework, Deloitte was re-appointed by the Members' Council as the Trust's auditor from 1 October 2015 for a three-year period.

Although its original intention was to tender for internal audit services during 2015, the Audit Committee took the view that, given the changes within the organisation currently, engendering such a change would present an unnecessary risk to the Trust. As a result, the Committee agreed to extend the contract for KPMG as the Trust's internal auditors for a further year to 30 July 2017.

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 2016. To strengthen its arrangements, the Trust's approach in 2015/16 has been to review guidance and policies, take a targeted approach to providing advice and support to staff through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended EMT, re-branding of materials, and offering advice and increasing availability of training for staff. 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.

Early in 2015/16, the Trust was asked to sign an undertaking by the Information Commissioner's Office due to data breaches under the Data Protection Act 1998 involving staff sending misdirected mail. There were eight incidents of mail being sent to the wrong address recorded during quarter 1 of the year. Action was taken by the Trust, including communication to all staff highlighting this issue and providing a number of practical steps to follow for all mail going forward. The Information Governance team also launched bespoke training packages to ensure that staff are clear on how Information Governance relates to them.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioners Office. There have been two such incidents in 2015/16. One related to a complaint received by the Trust from a solicitor acting on behalf of the mother of a child that was a previous service user in relation to an incorrectly addressed letter containing sensitive information. Some of this information was then uploaded to social media. An investigation was initiated and action taken as a result. The other incident related to a serious IT virus affecting the Trust's network in August 2015. The virus resulted in all of the Trust's systems being shut down across all locations. The Trust worked with its IT service provider to rectify the problem and business continuity plans were implemented. Although staff were unable to use electronic systems, there was no reported impact on the service the Trust provides to its service users/patients. The Trust instigated an investigation into the incident and its own response and a number of areas from which the Trust can learn have been identified.

## 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 BDU 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 to approve the Quality Report.

Governance and leadership

There is clear corporate leadership of data quality through the Deputy Chief Executive, Director of Finance and Director of Nursing 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 information governance and RiO training.

The Director of Nursing chairs the Trust-wide group that oversees the Trust's approach to improving the quality of clinical information. 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 policies or procedures to secure the quality of the data recorded and used for reporting. It is also tasked with ensuring the Trust has in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality. The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

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 Delivery 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 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 developed a values-based appraisal system for staff in 2013 and has a target for all staff in bands 6 and above to have an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. Although this is 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). A detailed action plan was submitted to address the compliance issues, which was fully completed in June 2014. The CQC has yet to confirm that the compliance actions are closed.

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 2015 to March 2016, XX internal audit reports were presented to the Audit Committee. 'Significant assurance' was received for XX reports and 'significant assurance with minor improvement opportunities' given in XXX areas. XXX reports were given 'partial assurance with improvement required' in relation to XXXX. There were no reports given a 'no assurance' rating.

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.

XXX reviews are ongoing at the end of the year and are due to report to the Audit Committee in July 2016.

The Head of Internal Audit's overall opinion for 2015/16 is one of XXXXX.

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 Improving Clinical Information 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. BDU 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, which supports me in the 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, its Board and members of the leadership and management structure 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.



**……**

**Chief Executive**
**24 May 2016**

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 8.2

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| **Title:** | **Decision-making framework** |
| **Paper prepared by:** | Deputy Chief Executive and Director of Corporate Development |
| **Purpose:** | To update on the processes the Trust has adopted for the review of the Standing Orders (SO), Standing Financial Instructions (SFI) and the scheme of delegation, the progress made and the actions still to be completed. |
| **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 Trust Board of 'How the organisation runs' during 2015/16 and a paper to the Board on 28 April 2015. |
| **Executive summary:** | • The Standing Orders, Standing Financial Instructions and Scheme of Delegation are a key element of the governance framework of the organisation, describing the processes by which the use of resources is managed, what controls are in place to ensure proper accountability and compliance with regulations and what decisions are reserved for Trust Board.<br>• Any review of governance processes and supporting documentation should 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'.<br>• 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.<br>• The revised governance documents should provide the following.<br>- Clarity on those things that require compliance and, therefore, are not negotiable, such as, compliance with tendering procedures and ensuring appropriate authorisation or escalation.<br>- 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.<br>- 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.<br>- Enable clarity of roles and responsibilities between the Quality Academy and BDU senior managers and staff.<br><br>Key activities undertaken to date.<br>1. Ongoing development of the operational 'trios' and deputy director posts in BDUs, which has enabled a much clearer definition of clinical leadership and operational |

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| | management linked to delivering quality.<br>2. Quarterly time out with the Executive Management Team and Deputy Directors implemented to explore the schemes of delegation and ways of working;<br>3. Alignment of the content with the Leadership and Management Strategy (May 2015) and the application of the micro/meso/macro model.<br>4. Ongoing development of service line reporting. This has been used in 2015/6 to give greater clarity on the relative use of resources for the purpose of identifying a strategic approach to service sustainability through the annual planning exercise and development of bid propositions. The methodology has also been used to develop a pricing strategy which has been presented to Trust Board.<br>5. Review of SFI's and Standing Orders by Director of Finance, including benchmarking of financial limits with other organisations. At the Audit Committee in April 2016, a paper will be presented on 'Authorisation levels for procurement and tendering' with the recommendation not to change the current position for authorisation levels in relation to procurement and tendering.<br>6. A Chief Executive review of delegated limits has concluded with a recommendation to Trust Board that the limits stay as at present:<br>a. Trust Board approval of Outline and Final Business Cases for Capital Investment above £500,000 or a series of projects for which the combined value would exceed £1 million;<br>b. Trust Board to approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a three-year period or the period of the contract if longer;<br>c. Trust Board approval of any procurement arrangement that commits the Trust to expenditure above £500,000 over the life of the arrangement.<br>7. Reservation of Powers to the Trust Board and Delegation of Powers is being reviewed by the Director of Corporate Development in her role as Company Secretary, which will be presented to the April Board.<br>8. Implementation of Well-Led action plan ensuring alignment of the Annual Plan Performance dashboard, quality impact assessments, Strategic Plan and Strategic Dashboard with the decision-making framework and alignment with the design and completion of objectives for 2016/17. A review of the decision-making framework was undertaken at the EMT time out in February 2016. This will be completed as part of the process to finalise the Annual plan and strategic objectives in April 2016. |
| **Recommendation:** | **Trust Board is asked to NOTE the report, the work undertaken to date, raise any issues for clarification and APPROVE the recommendation at point 6 above.** |
| **Private session:** | Not applicable |

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 8.3

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| **Title:** | **Calderdale Vanguard partnership agreement** |
| **Paper prepared by:** | Deputy Chief Executive |
| **Purpose:** | For Trust Board to consider approval of the Calderdale Vanguard Partnership Agreement including granting delegated authority to Trust staff participating in the Vanguard Board. |
| **Mission/values:** | The Calderdale Vanguard is a Multi-Specialty Community Provider Vanguard, part of the national New Care Models programme. It aligns to the Trust's mission in respect of working with partners at local level to enable people to live well in their community. |
| **Any background papers/ previously considered by:** | The Executive Management Team considered the agreement at its meeting on 17 March 2016 and supported its submission to Trust Board for approval. |
| **Executive summary:** | The purpose of the report is to:<br>• update on progress of the Calderdale Multi-Specialty Community Provider Vanguard, and the engagement of this Trust in that work;<br>• note the content of the Calderdale Vanguard Partnership Agreement (CVPA);<br>• note the changes to the CVPA that are suggested by the Deputy Director of Strategic Planning;<br>• note the request for delegated authority to be granted to the District Director for Calderdale and Kirklees, and the Deputy Director of Strategic Planning; and<br>• request that Trust Board considers approving the Calderdale Vanguard Partnership Agreement, subject to suggested amendments.<br>**The Calderdale Multi-Specialty Community Provider Vanguard**<br>This Vanguard scheme is part of the national New Care Models Programme which supports the Five Year Forward View. It intends to explore approaches to integrated locality based health and wellbeing. The initial focus is on testing new ways of working in the rural 'Upper Valley' locality.<br>The Vanguard secured an initial tranche of funding for Q4 2015/16 and is currently awaiting the outcome of a further funding request for 2016/17 – 2017/18.<br>Partners in the Calderdale Vanguard include the Pennine GP Alliance (GP Federation) which hosts the Vanguard project management office, Calderdale and Huddersfield NHS Foundation Trust, Voluntary Action Calderdale, and both local authority and local NHS commissioners.<br>Key developments through the Vanguard in which the Trust is participating include:<br>• integrated locality care model into which this Trust is contributing expertise regarding older peoples' mental health, frailty and care home support;<br>• piloting of a First Point of Contact to support timely access to information, signposting and referral. It is likely that the initial focus of the First Point of |

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| | Contact will be child and adolescent mental health services (CAMHS).<br><br>The Vanguard governance arrangements are as follows.<br>• Led by a Board, on which this Trust has two places (one voting and one non-voting). The District Director holds the voting position and the Deputy Director of Strategic Planning holds the non-voting position.<br>• Nine Work Streams covering the locality model of care, extending support for self-care, the First Point of Contact, and various 'enablers' such as workforce. The Trust is presently reviewing representation within these work streams to ensure that we are appropriately engaged and that we support and co-ordinate the efforts of all colleagues involved.<br><br>**The Partnership Agreement (CVPA)**<br>The relationships and respective responsibilities between partners in the Vanguard are described in a draft Partnership Agreement document. All organisations participating in the Vanguard are currently reviewing the CVPA and seeking its approval via the appropriate organisational governance processes.<br>The CVPA is attached but essentially asks each organisation to:<br>• commit or source resources to enable the programmes activities to be successfully achieved<br>• support the development of the annual Value Proposition<br>• respond promptly to requests for information in order to complete Vanguard and NHS England monitoring requirements<br>• work to the following principles; think system, not organisation; be brave and take risks to do the right thing; take an asset-based approach to promote health and wellbeing<br>• ensure that appropriate level representation with authorisation for decision making on behalf of their organisation, is made available for each level of governance<br>Following review by the Director of Health Intelligence and Innovation and the Deputy Director of Strategic Planning, a number of amendments to the CVPA have been suggested. These are highlighted in the document but in essence they are as follows.<br>• Clarify ownership of intellectual property created by Vanguard partners prior to or otherwise outside the Vanguard. To confirm that such intellectual property (IP) should remain the property of the organisation that created it. This makes clear the distinction with IP created by partners in the course of the Vanguard work which is stated in the Partnership Agreement to be the property of the Calderdale Vanguard.<br>• Limit the risk sharing arrangements in respect of employment liabilities incurred by other organisations participating in the Vanguard. Clarifying that this Trust does not accept any shared liability for costs of redundancy relating to staff employed by other organisations to deliver the Vanguard work.<br>• Limit the Trust's financial commitment to the Calderdale Vanguard Programme Team. Specifically be deleting a clause that states "partners agree to the ongoing funding for the Vanguard Programme Team for the duration of the Vanguard (as a minimum)" and replacing with a statement to the effect that commitment is limited to the extent that the Vanguard is |

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| | funded by the New Care Models Programme.<br><br>The Trust Board is asked to consider approving the CVPA subject to the suggested amendments.<br><br>**Request to grant delegated authority**<br><br>As highlighted above the CVPA asks each organisation to grant delegated authority to its representatives on the Vanguard Board. The extent of this authority is that:<br><br>• members of this group must have the delegated authority of decision making on behalf of their organisation to enable fast paced decision and action, subject to the terms within the organisation's scheme of delegation;<br><br>• in the event that the voting Member of a partner organisation cannot attend the meeting, the non-voting Member from that organisation may exercise their vote;<br><br>• members are responsible for proactively keeping their own organisation informed of decisions and progress.<br><br>These powers are initially vested in the voting Board members (in the case of this Trust, the District Director for Calderdale and Kirklees); however, in the event that the voting member is not present, the non-voting member (Deputy Director of Strategic Planning) is asked to assume the same responsibilities on behalf of their organisation.<br><br>The Trust Board is asked to consider approving the above delegated authority for the District Director and Deputy Director. |
| **Recommendation:** | **Trust Board is asked to:**<br><br>• **NOTE the Trust's engagement with the Calderdale Vanguard; and**<br><br>• **APPROVE the Calderdale Vanguard Partnership Agreement including associated delegated authority to act, subject to the changes that are proposed to the draft document.** |
| **Private session:** | Not applicable |

# Calderdale 5 Year Multi-Speciality Community Vanguard

# Partnership Agreement







**Calderdale 5 Year Multi-Speciality Community Vanguard**
**Partnership Agreement**

## 1.0 Introduction

The Calderdale Vanguard Multi-Speciality Community Vanguard is made up of the below, referred to throughout as the Partners:

- Pennine GP Alliance
- Calderdale and Huddersfield Foundation Trust
- Locala CIC
- South West Yorkshire Partnership NHS Foundation Trust
- The Third Sector / VCS
- Calderdale CCG
- Calderdale Metropolitan Borough Council

These partners have been engaged in an ambitious programme of change that has resulted in the development of an ambitious hospital change programme and the commissioning of a new integrated health and social care integration programme - Care Closer to Home (CC2H). This work sits within a backdrop of extensive public and stakeholder engagement. Although underway the Partners believe that the Vanguard will provide an accelerant which will deliver benefit at greater pace and scale.

## 2.0 The Vanguard Portfolio

Is made up of 4 programmes and a number of enablers:

Programmes

- Prevention and Healthy Lifestyles
- Supported Self- Managed Care
- Integrated Health and Social Care First Point of Contact
- Integrated Community Model

Enablers

- Workforce and Organisation Development
- Estates
- Information Management & Technology including Information Governance
- Transport
- Communications, Engagement, Equality and Marketing

## 3.0 The Vanguard Aims

- Develop care and support offers which are; person-centred, personalised, co-ordinated, empowering - created in partnership with carers, citizens and communities and supported by volunteering and social action
- Transform the way our system currently operates so that there is greater focus on the prevention of ill health, resulting in reductions in premature death and dependency and improvement in health, health inequalities and wellbeing
- Shift the balance from avoidable hospital admissions to integrated health, social care and third sector models delivered in community and primary care settings

- Ensure the work is aligned to the four core values of the New Care Models (NMC) Programme i.e. / clinical engagement, patient involvement, local ownership and national support
- That it has a high degree of replicability in our work, which provides a benefit much wider than Calderdale itself

## 4.0 The Model will

- Prevent ill health and enable people to stay independent for as long as possible
- Prevent premature death, with people living as long as possible
- Support people to recover from an episode of ill health and injury
- Build resilience in individuals and communities
- Ensure high level of satisfaction with access and service provision

## 5.0 The Case for Change

- Equitable and easy access to services is challenged by geography and demographics
- Patients have expressed their desire to improve self-management, especially for long term conditions and to reduce dependency and social isolation, requesting more holistic care plans and integrated ways of working
- There is potential to maximise community estate to better support community offers and support the sustainability agenda
- There are significant workforce challenges and the need to change culture and ways of working
- There is a requirement to make long term financial savings which make the system viable and sustainable

## 6.0 NHS England Requirements for Vanguards

In order to be compliant with the requirements of NHS England of the Vanguard the Partners agree to:

- Collaborate with other Vanguards, New Models of Care and NHS England Account Management Team
- Deliver demonstrable value for any national investment across the triple aims of; health and wellbeing, care and quality and delivering financial efficiency
- Ensure national replicability and spread is built into the Vanguard modelling from the outset. Noting that "the success of the Vanguard and value delivered for the taxpayer will not be defined by successful local delivery in the vanguard system, but the extent to which they have made it easy to spread learning across the NHS and Social Care" NHS Partnership Agreement Sept 15 p2 Principle 2
- Keep the New Models of Care Account Management Team appraised of developments to ensure continued tailored support and that learning from all Vanguard work is shared

## 7.0 Intellectual Property

The intellectual property rights in any products, documents or other know-how produced by partners as part of their Vanguard work is the intellectual property of the Calderdale Vanguard.

- The Partners agree that all such products, documents and know-how can and will be shared at no cost with the NMC Programme or other Vanguard sites or other organisations involved in the development of new care models

- The Partners will ensure that they reserve the ability to do this in any contracts or other agreements (including licences) entered into with third parties, including professional advisers, producing such products, documents and/or know how on the Calderdale Vanguards behalf
- The partners accept that the intellectual property rights in any products, documents or other know-how produced by the NCM Programme will remain the property of the NCM Programme

The intellectual property rights in any products, documents or other know-how produced by partners prior to or otherwise outside their involvement in the Calderdale MCP Vanguard, shall remain the intellectual property of the originating organisation. No claim shall be made by the NCM Programme over such products, documents or other know-how.

## 8.0 Vanguard Funding and Monitoring

- The funding shall be allocated by the Vanguard Board in line with the Value Proposition and governance arrangements, following Funding Requests from the Programmes and Enablers, who will have had their funding requests verified by the Finance Enabler Group
- The Partners understand that any savings or achievements will be allocated via the Vanguard Board in line with their Terms of Reference
- The Partners will, via the Vanguard Board, ensure that the work of individual programmes and projects is adequately resourced in terms of both funding and people (using Vanguard monies and existing money across the system) and managed to deliver to time and plan
- The Partners will commit or source resources to enable the programmes activities to be successfully achieved, via the Vanguard Board
- The Partners will support the development of the annual Value Proposition by responding promptly and within deadlines to requests for information or support

- The Partners will respond promptly to requests for information in order to complete Vanguard and NHS England monitoring requirements
- The partners understand that during New Models of Care Programme quarterly monitoring, agreed milestones will be reviewed and the associated investment profiled in line with achievement or non-achievement
- The Partners understand and accept that where a potential underspend is identified at the end of the financial year, NHS England's Finance Team will liaise directly with the Vanguards Finance Lead in order to agree the required steps

## 9.0 Principles

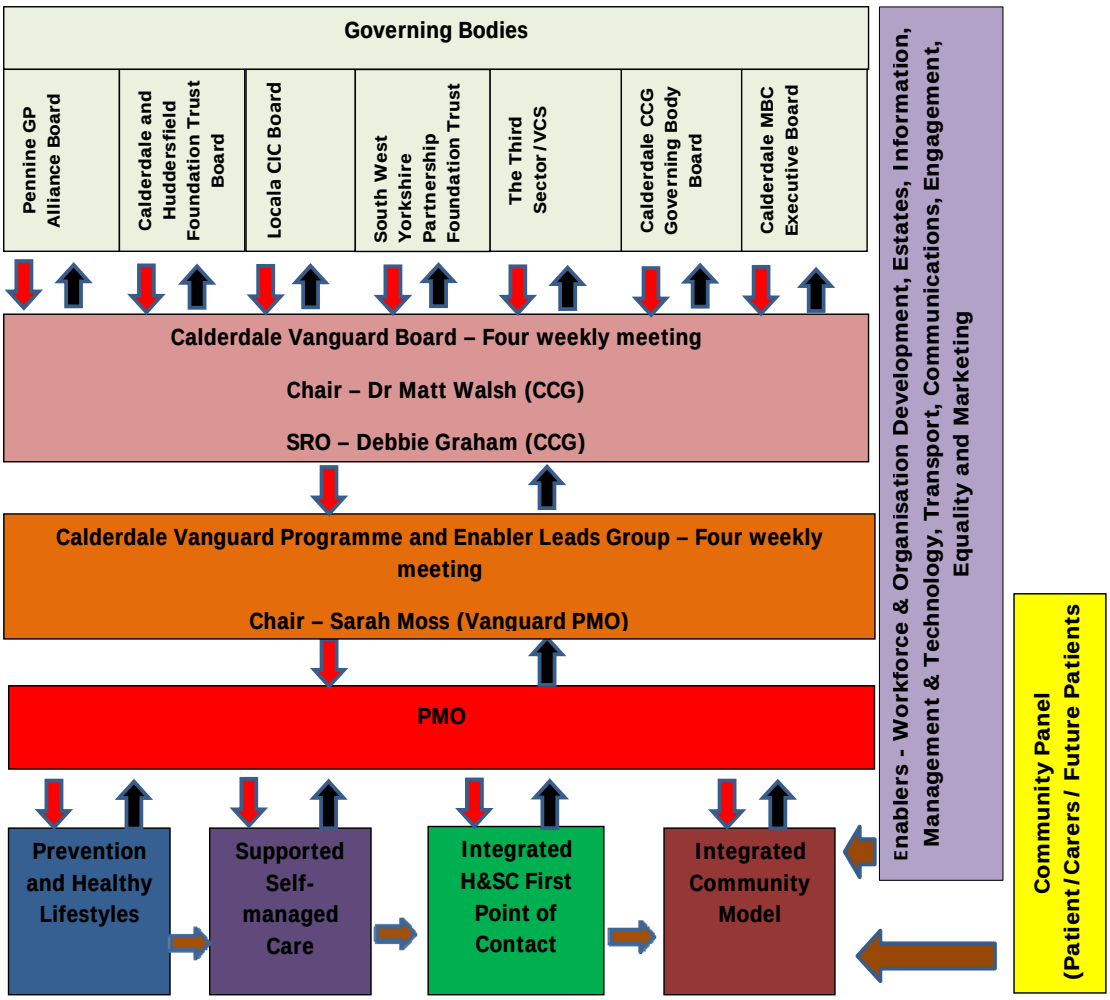
The Partners agree to work to the following principles:

- Thinking must be system, not organisation/sovereignty based
- Being brave and taking risks to do the right thing
- Understanding that we all need to change. Its not about preaching to others
- Acknowledging the wins on the journey and taking time to give ourselves credit for progress being made and sharing the progress appropriately
- Ensure that an asset-based approach is taken to promote the health, wellbeing and independence of people in Calderdale

## 10.0 Governance

The Calderdale Vanguard will use practical programme management tools and support to add rigour and accountability to the work.

- To support this approach the following governance has been established, with Terms of Reference available for each level that incorporate the previously agreed Design principles
- It is important to note that a principle applied throughout the governance is joint commissioner and provider leadership
- A further principle is the importance of having a professional and or clinical voice on each programme, enabler, group and board
- A Community Panel will be established to be the voice of the public (patients, carers and future patients) to provide a review and challenge role for all plans and documents to ensure that we do not lose sight of people being at the heart of any changes that we make.



- The Partners agree to ensure that appropriate level representation, with authorisation for decision making on behalf of their organisation, is made available for each level of the governance to act in line with the agreed Terms of Reference
- The Partners will ensure that their representative at each level of Governance attends regularly and abides by the Terms of Reference
- ~~The Partners agree to the ongoing funding for the Vanguard Programme Team for the duration of the Vanguard (as a minimum)~~The Partners agree to the ongoing funding of the Vanguard Programme Team for such time that the costs of the Programme Team are met by the national NCM Programme via acceptance of annual Value Propositions. In the event that the national programme does not fully fund the Programme Team and the Partners choose to continue the Vanguard work there will be an explicit agreement between partners regarding funding choices.

## 11. Recruitment Risk Management

Where costs of redundancy are incurred in relation to The Programme Team or any other ~~known from the outset, such as redundancy costs~~ fixed term posts specifically recruited to enable the delivery of the Vanguard, the Board may partially indemnify the employing organisation against such costs. The conditions of such indemnity are:

- An explicit agreement has been reached by the Board on a post by post basis prior to entering into the employment that gives rise to the liability.
- An adequate contingency fund to cover such redundancy costs has been secured from the national NCM Programme via acceptance of annual Value Proposition.

In all other circumstances the costs of redundancy remain the responsibility of the employing organisation.

~~For the avoidance of doubt it should be understood that the Boards liability will be for the duration of their employment specifically for the Vanguard only.~~

Where individual partner organisations recruit long term posts aligned to the direction of travel of the Vanguard, that are planned to continue beyond the completion of the Vanguard, Partners accept that these posts are the responsibility of the employing organisation as they would be classed as 'business as usual'.

~~In the situation where the annual NHS England annual Vanguard funding is not obtained, or significantly reduced from the requested amount, before the Vanguard has achieved its necessary savings, then any redundancy costs would be obtained from the small contingency allowance.~~

~~For the avoidance of doubt it should be understood that the Boards liability will be for the duration of their employment specifically for the Vanguard only.~~

In the event that a Partner is taken to an employment tribunal by staff employed, who are in any way involved in the Vanguard work, then this shall be the sole responsibility of the employing organisation. This does not preclude any defence or cause of action that may exist between Vanguard Partners.

**Partner Signatures**

Dr Matt Walsh

Chief Operating Officer — Signed:……

NHS Calderdale Commissioning Group — Date:……

Paul Butcher

Director of Public Health Signed:……..

Calderdale Metropolitan Borough Council Date:……..

Rosemary Cowgill

PGPA Community Director Signed:……..

Calderdale Vanguard Date:……..

Dr Soo Nevison

Chief Officer Signed:……..

Voluntary Action Calderdale Date:……..

Catherine Douglas

Head of Business Development Signed:……..

Locala Community Partnerships Date:……..

Anna Basford

Director of Transformation & Partnerships Signed:……..

Calderdale and Huddersfield NHS Foundation Trust Date:……..

Karen Taylor

District Director Signed:……..

South West Yorkshire Partnership Foundation Trust Date:……..

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 29 March 2016
# Agenda item 9

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| **Title:** | **Use of Trust seal** |
| **Paper prepared by:** | Chief Executive |
| **Purpose:** | The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders. |
| **Mission/values:** | The paper ensures that the Trust meets its governance and regulatory requirements. |
| **Any background papers/ previously considered by:** | Quarterly reports to Trust Board |
| **Executive summary:** | The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive.<br>The seal has been used eighteen times since the report to Trust Board in December 2015 in respect of the following.<br>- Deed of Release relating to Britannia Works, Garden Street, Halifax.<br>- Licence to occupy the café area at Laura Mitchell Health Centre, Halifax, between the Trust and Calderdale Council.<br>- Transfer of Registered Title and contract for sale of freehold land, Royston Clinic, Royston, between the Trust and purchasers.<br>- Planning Obligation under Section 106 of the Town and Country Planning Act 1990 relating to land at Savile Park, Castleford, between Wakefield Council and the Trust.<br>- Supplemental Deed relating to Aberford Road, Wakefield, between the Trust and Miller Homes Limited.<br>- Deed of Surrender relating to Folly Hall (ground floor), Huddersfield, between Bradbury Investments Limited and the Trust.<br>- Deed of Variation relating to Folly Hall, Huddersfield (seven variations) between Bradbury Investments Limited and the Trust.<br>- Underlease relating to Folly Hall, Huddersfield, (ground floor) between Bradbury Investments Limited and the Trust.<br>- Transfer of Registered Titles for land to the east of Aberford Road, Wakefield, between the Trust and Miller Homes Limited.<br>- Transfer of Registered Title for electricity sub-station, Princess Street, Barnsley, between Northern Powergrid (Yorkshire) plc and the Trust.<br>- Lease of land and easements at New Street Health Centre, Barnsley, |

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| | between the Trust and Northern Powergrid (Yorkshire) plc. |
| **Recommendation:** | **Trust Board is asked to NOTE use of the Trust's seal since the last report in December 2015.** |
| **Private session:** | Not applicable |