With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (public session)
Tuesday 25 June 2013 at 9:30
Manor room, 5th floor, F Mill, Dean Clough, Halifax

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 30 April 2013

4. Assurance from Trust Board Committees

4.1 Audit Committee 9 April and 23 May 2013
4.2 Clinical Governance and Clinical Safety Committee 16 April, 7 May and 17 June 2013 (verbal)
4.3 Mental Health Act Committee 7 May 2013
4.4 Remuneration and Terms of Service Committee 23 April 2013

5. Chief Executive's report

6. Annual report, accounts and Quality Report 2012/13

7. Month 2 performance reports 2013/14

7.1 Section 1 – Quality performance report month 2 2013/14

7.2 Section 2 – Finance report month 2 2013/14

7.3 Section 3 – Exception reporting and action plans

(i) Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis II) – Trust action plan
(ii) Annual serious incidents report
(iii) Complaints annual report 2012/13
(iv) NHS Constitution – Trust assessment
(v) Change to Care Quality Commission Statement of Purpose

8. Use of Trust seal

9. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 23 July 2013 in the Wainhouse room, 5th Floor, F Mill, Dean Clough, Halifax

Minutes of Trust Board meeting held on 30 April 2013

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Bernard Fee	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
In attendance:	Anna Basford	District Service Director, Calderdale and Kirklees
	Adrian Berry	Director of Forensic Services
	Sean Rayner	District Service Director, Barnsley and Wakefield
	Dawn Stephenson	Director of Corporate Development and Constitutional Affairs
	Karen Taylor	Director of Service Improvement and Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	None	
Guests:	Penelope Fairmann	Regional account manager, Otsuka Pharmaceuticals (UK) Ltd.
	Andrew Hill	Members' Council (publicly elected, Barnsley)
	Bob Mortimer	Members' Council (publicly elected, Kirklees)

TB/13/19 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. There were no apologies. He congratulated Anna Basford (ABa) on her appointment as Director of Commissioning and Partnerships at Calderdale and Huddersfield NHS Foundation Trust.

TB/13/20 Declaration of interests (agenda item 2)

Trust Board considered the following additional declaration.

Name	Declaration
EXECUTIVE DIRECTORS	
Nisreen Booya	Honorary President of the Support to Recovery (Kirklees mental health charity) Secondary care doctor member, Bassetlaw Clinical Commissioning Group Panellist, Medical Practitioners' Tribunal Service

There were no comments or remarks made on the declaration, therefore, **it was RESOLVED to formally note the declarations made above.** There were no other declarations made over and above those made in March 2013.

TB/13/21 Minutes of and matters arising from the Trust Board meeting held on 26 March 2013 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 26 March 2013 as a true and accurate record of the meeting. There was one matter arising.

TB/13/14 Approval of annual plans and budget 2013/14

As discussed in March, in future years, the process to approve the annual plans and budget will include a briefing session to review the detail prior to the formal Trust Board meeting.

Bernard Fee (BF) welcomed the proposed approach; however, he was increasingly uncomfortable and concerned that the budget discussion was curtailed in March given the issues raised and the view that these were not satisfactorily addressed by some members of the Board. IB noted BF's comments. The Chief Executive (SM) added that there would be an opportunity to work through any residual issues at the development session in May.

TB/13/22 Performance reports month 12 2012/13 (agenda item 4)

TB/13/22a Quality performance report (item 4.1)

Tim Breedon (TB) took Trust Board through the key points in the report.

- The key focus for the report in 2013/14 will be progress against quality priorities and enhanced patient experience reporting.
- The Trust achieved its information governance training target.
- The Care Quality Commission (CQC) has appointed a new 'partner' for the Trust covering the whole of the organisational footprint. It is expected that this will result in a more robust approach.
- Cross-Trust workshops have been held to review the recommendations in the Francis Report and agree where further assurance is required. An action plan will be presented to the Clinical Governance and Clinical Safety Committee and Trust Board in June.
- There will be further development of the Business Delivery Unit (BDU) quality governance framework.

Alex Farrell (AF) commented on the following.

- There was a £600,000 underperformance on CQUINs at the end of 2013/13, which mainly related to health and wellbeing, and access targets.
- There has been an improvement in performance against Improving Access to Psychological Therapies (IAPT) targets; however, achievement of targets in 2013/14 will be challenging.
- Clustering will become increasingly important in 2013/14 and the Trust will closely monitor the impact of clustering on BDU positions.

IB commented that there is a perception that accident and emergency services are in crisis. He asked if there is an area of Trust services that should have a degree of scrutiny. TB responded that the A&E interface between the Trust and acute trusts, particularly around this Trust's response to four-hour targets, is an area for urgent review. SM commented that there are broader issues around mental health crisis services as a whole of which this is just a part and will also include home-based treatment and police liaison.

Nisreen Booya (NHB) added that this will form part of the transformation programme, particularly how crisis services work with community teams, how this relationship can be improved and how the capacity of crisis services can be increased. This is a national issue and the Trust is looking at the practice of other Trusts to learn from best practice.

SM commented that the ImROC (Implementing Recovery through Organisational Change) programme includes targets in relation to service users in employment and the Trust should be monitoring this more closely. He also commented that the Trust has a new relationship manager at Monitor and Monitor will undertake a review in quarter 4, which will include a visit to the Trust.

TB/13/22b Finance report month 12 2013/14 (item 4.2)
AF highlighted the following.

- The financial risk rating is green at 4.3 against a plan of 3.6.
- There is a net surplus of £6.05 million, which is £0.12 million ahead of the £5.93 million plan. This is mainly due to an increase in provisions and a reallocation of capital funding against revenue.
- At month 12, the cost improvement programme has underperformed by £79,000 against a plan of £9.3 million.
- Capital expenditure is at £9.2 million, which is £1.1 million below plan due the an underspend on the Fieldhead site development and deferment of investment in the Trust's clinical information system (RiO) to 2013/14.

AF was asked to explain the financial position in relation to sickness absence. She explained that the overspend related to the use of bank and agency staff. The underspend at month 2 was £500,000, which would pro-rate to an annual figure of over £6 million; however, this was actually £2.6 million as use of bank and agency was managed and reduced dramatically from month 3 of 2012/13.

BF asked why there had been an increase in provisions. AF responded that this reflected an increase in the redundancy provision to £5 million. This includes £3.2 million for named individuals to support the cost improvement programme and synergies; £1 million relates to Director plans to re-structure departments and teams; and the remaining is provision for 2014/15 in relation to the transformation programme. She stressed that it is not related to any major organisational re-structure. The Trust has agreed the accounting treatment with Deloitte and the level of evidence provided by the Trust was accepted. BF responded that he did not understand why the position had changed so dramatically. AF responded that it became apparent in the detailed work to set budgets and agree cost improvements for 2013/14; however, there has been no change to the cost improvement programme.

PA commented that £1.1 million came out of operational expenses and went to provisions in month 12 whilst the Trust still met its final budget. He asked whether there was a similar contingency in 2013/14. AF responded that it is intended to deliver balance on the plan in 2013/14 across all BDUs.

IB commented that there will be a formal review by Trust Board of the position and end-of-year outturn in October 2013. PA asked that there is ongoing review during the year and AF confirmed there would be an update on provisions in each quarter.

TB/13/22c Strategic HR report month 12 2013/14 (item 4.3)
Alan Davis (AGD) highlighted the following.

- The biggest challenge in 2013/14 is the sickness absence target and this is reflected across Yorkshire and the Humber. The biggest cause of absence is stress and anxiety, which is not necessarily work-related. There have been good signs of improvement over the last quarter and the report captures the approach by BDU.
- The staff support service has been re-designed and a rapid access prevention service introduced to support staff to remain at work.
- There is a big cultural issue around sickness absence, which the Trust will address through the wellbeing/staff survey outcomes and engagement with staff. There has been a good response to the wellbeing survey with over 2,000 responses, which provides a good base for benchmarking by BDU and support services to implement the wellbeing engagement programme.

- The appraisal target was achieved. The appraisal system has been re-designed for 2013/14 and adopts a values-based approach to promote a performance improvement culture.

Sickness absence

BF commented that he understood the point made by AF about the cost of absence; however, there is an inherent absence rate, which results in consistent expenditure in the system. In reality, the real cost is 1.4% and this is where the Trust should focus its efforts. The Trust needs to think differently about the real cost of sickness.

He also commented that last month Trust Board approved a budget knowing that it is unachievable and, for him, this presents a real issue with the way Trust Board operates.

AF reiterated her previous comments explaining that the Trust has to consider the balance between headroom, level of vacancies, level of sickness absence and the level of bank and agency staff used, and where this is out of sync in BDUs. This has enabled a focussed approach to the use of bank and agency staff. The Trust cannot eliminate all sickness absence; however, work with BDUs does show where efforts should be focussed. BF repeated that he has no confidence in the plan put forward and no confidence that the Trust will meet the target as there is no historical example of the Trust doing so.

IB asked BDU Directors to comment on achievement of the target.

ABa responded that in Calderdale, there is an increased focus on sickness management and a robust management approach. The number of staff with long-term sickness absence has reduced. She was confident of and assured by the grip managers have but the target in 2012/13 was not achieved. In Kirklees, sickness is largely a problem in older people's services, with adult services achieving the target. Sickness absence has increased over the winter period in older people's services. Again she is assured by the management of absence and the process. The target of 4.25% will be stretching but not unachievable.

Sean Rayner (SR) responded that there has been a year-on-year continuous improvement in Barnsley over the last five years. Mental health services have particularly improved. Consistent application of the policy remains an issue and targeted activity is key to resolving absence issues, which has been evidenced through improved performance against the target. In Wakefield, there has also been a year-on-year improvement with a substantial reduction over the past year. The same principles as in Barnsley need to be applied. The target should be achieved in Barnsley; Wakefield will be more challenging but there is a robust trajectory and management teams are working to this.

In Forensic services, Adrian Berry (ABe) confirmed that the target will be challenging despite management efforts to achieve it. There is consistent application of the policy, which has been confirmed by a sub-group set up with staff side to look at sickness absence. There has been a quarter-on-quarter improvement in medium secure services and a dramatic reduction in long-term sickness absence. The target will be a big challenge; however, following the trajectory in 2012/13, could be achieved. There has been an increase in sickness absence in low secure services, both for long- and short-term absence. There has been a significant change in management and this will see the trajectory coming down; however, it is unlikely that the target will be achieved.

SM commented that the best indicator of future performance is previous performance. There is a significant cultural challenge in low secure services and this affects forensic achievement overall. The aspiration is for 4.25% but operational planning needs to consider whether this can be achieved. As already stated, the Trust needs to be realistic in its budget and its plans.

Peter Aspinall (PA) commented that there is a 1% gap and, however this is costed, it is a large proportion of the Trust's funds and changing the culture will be difficult. He asked at what point the Trust would seek external consultants to support improvements. AGD responded that 4.25% has always been seen as a stretching target. The Trust operates in the context of the NHS both regionally and nationally and some approaches are not open to the Trust as it is bound by national terms and conditions. The Trust has to look at best practice and other ideas and tools; however, the Trust benchmarks very well with other parts of the NHS.

Helen Wollaston (HW) commented that the consequences of not meeting the target have been discussed at the Remuneration and Terms of Service Committee and the Committee was assured it would be part of the performance measures for managers.

BF commented that it is clear where the Trust can make improvements and where the target will and will not be achieved. He would, therefore, like to see the Trust introduce variable targets. Julie Fox (JF) felt the Trust should look at the longer-term, particularly how it will achieve the national average of 4%. The Trust is increasingly competing with the private sector and this should be accommodated in the target. She also commented that the transformational change programme will have an affect on staff and this needs to be considered. She suggested the Trust considers the overall target and makes accommodation for differences between BDUs. SM reiterated his point that, although the aspiration is to reduce the target to the national average of 4%, the Trust has to be realistic and root its targets in operational reality. AF commented that BDUs are developing a realistic trajectory for monitoring by the Executive Management Team to manage performance and demonstrate improvement, which will be reported to Trust Board.

Jonathan Jones (JJ) felt that seeking external advice did not present a positive view of the organisation. It would not reflect very well on the Trust and the Trust should be capable of identifying best practice and applying it to its business. He supported the move to link performance objectives and remuneration.

In summary, IB asked SM to consider PA's suggestion that the Trust seeks external support and advice. There will be a further discussion on sickness absence at the meeting in July 2013 with further scrutiny and understanding of the detailed operational figures at service level by the Remuneration and Terms of Service Committee.

TB/13/22d Exception reports and action plans – Quarterly serious incidents report (item 4.4(i))

TB highlighted the following.

- A root cause analysis master class for serious incidents investigators has been held to improve investigations, improve the length of time taken to produce reports and improve the recommendations made as a result of investigations.
- There has been a review of the Incident Review Sub-Group, which will focus on performance and assurance regarding serious incidents processes, and the Clinical Reference Group, which will focus on learning lessons.

As reported to Trust Board in March 2013, following receipt of the Rule 43 Letter, the Trust has agreed to provide a joint response to the recommendations with Mid-Yorkshire Hospitals NHS Trust (MYT). A number of 'next steps' were agreed by the Director of Nursing, Medical Director and Deputy Director of Operations (Wakefield) with MYT's Director of Nursing, Medical Director and Chief Operating Officer. A further meeting will be held on 2 May 2013 to review progress and agree the initial response to the Coroner. TB confirmed that the review report will be finalised within twelve weeks and will cover Wakefield and North

Kirklees in the first instance. With BDU Directors, he will then agree how it can be applied in Calderdale and Kirklees.

IB asked what investigation takes place and by whom of people who commit suicide and appear in the 'not known to the Trust' category. TB responded that the Trust has approached the Coroner in each district for information to enable the Trust to undertake an analysis of this group; however, as NHB explained, there has been a reluctance to share the information with the Trust. IB asked if there was any further action the Trust should take. NHB responded that there is ongoing discussion with clinical commissioning groups to agree a way forward. SM commented that this is a common picture nationally. It is important that the Trust understands the pattern across the Trust's area as a whole not just those defined as 'known to the Trust'. IB suggested this should be on the agenda of the Health and Wellbeing Boards as the Trust needs to know any themes behind other suicides, such as issues with access to Trust services. JF asked if the Trust should commission a piece of work to take this forward and it was agreed TB would take the suggestion and concerns through the Health and Wellbeing Boards.

BF informed Trust Board of the presentation of the outcome of a review of a number of suicides commissioned by NHB and undertaken by two Trust consultants. The findings highlighted a number of areas where the Trust could do things better. An action plan was requested by the Committee and this will come to the next meeting.

It was RESOLVED to NOTE the report and the updated on the Rule 43 Letter.

TB/13/22e Exception reports and action plans – Annual medical appraisal and re-validation report (item 4.4(ii))

Following NHB's introduction, HW asked about the value of the exercise. NHB responded that there had been no surprises; however, it is a good tool for raising awareness of the role and responsibility of medical staff in terms of quality, safety and standards of care, and has made medical appraisal more robust, providing a forum to reflect on individual performance. SM commented that it reinforces the role and responsibility of the medical workforce in leadership within the Trust.

It was RESOLVED to CONTINUE to support and resource the developing and running of the systems and processes necessary to ensure the Trust, Responsible Officer, and medical staff meet their obligations under medical re-validation.

TB/13/22f Exception reports and action plans – Risk assessment of performance targets (item 4.4(iii))

AF alerted Trust Board to the following.

- The Compliance Framework remains as 2012/13 for the first two quarters of 2013/14. From October 2013, a revised risk assessment framework will be in place and Monitor is currently consulting on this. She assured Trust Board there is no risk to meeting compliance targets in 2013/14.
- There is an increase in data reporting, which will have an impact on clinical systems and overheads for collecting information.
- The report contains a high level summary of CQUINs. These are similar to 2012/13 with the exception of forensic CQUINs, which are a departure from previous years. In terms of risk, the assessment is that the CQUINs are stretching with a £1 million financial risk.
- NHS England requires all contracts to be signed by today. The Trust is in a position to achieve this with the exception of Wakefield. A further meeting will be held today with commissioners in Wakefield and the Trust is hopeful the position can be resolved.

IB asked if there was a point where the Trust would not tender for a service due to the CQUINs or targets set. BF commented that this would be difficult to assess given the Trust's block contract. AF responded that this would be tested through negotiations with commissioners in terms of the Trust's strategic direction and quality priorities. SM commented that there would be a line where targets were unrealistic and unachievable and are designed by commissioners just to take money out of the system; however, this has not been the case for the Trust. It does, however, remain an issue due to the nature of the block contract. AF commented that the current position demonstrates the Trust's successful negotiation of its contracts.

It was RESOLVED to NOTE the report, the assessment of risk and the actions planned to mitigate the risk.

TB/13/23 Governance issues (agenda item 5)

TB/13/23a Monitor Code of Governance and Corporate Governance Statement (item 5.1)

Dawn Stephenson (DS) took Trust Board through the key points in the report. PA commented that he had asked DS how, in practice, D.1.2c (relating to decisions to appoint external advisers) would work. IB responded that this would be agreed with the Chair and/or the Chief Executive; however, all members of Trust Board have the ability to propose the appointment of external advisers and he did not think the Trust should over-design a process. Situations would become clear if the matter arose. PA replied that he would like to see a process in place and IB will discuss this further with DS.

JF also asked for the Corporate Governance Statement, under item 14, to include expertise around the criminal justice system and equality and diversity.

It was RESOLVED to CONFIRM that the self-assessment against the Monitor Code of Governance provides assurance that processes are in place to ensure compliance by the Trust, and CONFIRM that the Corporate Governance Statement provides the assurance needed for Trust Board to make the required self-certification.

TB/13/23b Annual Governance Statement (item 5.2)

SM introduced his Statement, which encapsulates the key issues in running the organisation in relation to risk.

It was RESOLVED to APPROVE the Annual Governance Statement for 2012/13. Trust Board noted that there may be some changes to the Statement following review by the Trust's external auditor, Deloitte, and **RESOLVED to DELEGATE AUTHORITY to the Audit Committee to approve a final version, if necessary, as part of its approval of the annual report and accounts on 23 May 2013.**

TB/13/23c Audit Committee annual report 2012/13 (item 5.3)

It was RESOLVED to SUPPORT the view of the Audit Committee that it can provide assurance that, in terms of the effectiveness and integration of risk committee, 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.

TB/13/23d Changes to the Trust's Constitution (item 5.4)

It was RESOLVED to APPROVE the changes to the Trust's constitution.

TB/13/24 Trust Board self-certification – Monitor quarter 4 return 2012/13 (agenda item 6)
It was RESOLVED to APPROVE the exception report and quarterly return to Monitor.

TB/13/25 Assurance Framework and organisational risk register quarter 4 2012/13 (item 7)
It was RESOLVED to:

- **NOTE the process for producing the 2013/14 Assurance Framework and assurances provided for quarter 4 2012/13;**
- **NOTE those areas where gaps in assurance have been identified through the Trust-wide risk register, which are being addressed through specific action plans led by the appropriate Director.**

TB/13/26 Date and time of next meeting (agenda item 8)
The next meeting of Trust Board will be held on Tuesday 25 June 2013 in the Manor Room, 5th floor, F Mill, Dean Clough, Halifax.

Signed …… Date ……

Minutes of Audit Committee held on 9 April 2013

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
Apologies:	Members	
	Jonathan Jones	Non-Executive Director
	Others	
	Paul Thomson	Partner, Deloitte
In attendance:	Robert Adamson	Head of Finance
	Ian Black	Chair of the Trust (by phone) (items 2 and part 4)
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety (items 2/3/6)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Ellie Cook	Manager, Deloitte
	Tony Cooper	Head of Procurement
	Tim Cutler	Head of Internal Audit, KPMG
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Julie Fox	Non-Executive Director
	Dawn Gibson	Deputy Director of Finance
	Paul Hewitson	Senior Audit Manager, Deloitte
	Clare Partridge	Senior Manager, KPMG
	Karen Sharrocks	Senior Manager, Local Counter Fraud Service, KPMG
	Dawn Stephenson	Director of Corporate Development

AC/13/17 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (PA) welcomed everyone to the meeting. The apologies were noted.

AC/13/18 Review of other Committees effectiveness and integration (agenda item 2)

The Audit Committee received the annual report from each Committee and forward work programmes. This was supported by a short presentation from the Chair of the Clinical Governance and Clinical Safety Committee, Julie Fox on behalf of Helen Wollaston, Chair of the Mental Health Act Committee, and Ian Black, Chair of the Remuneration and Terms of Service Committee, to provide assurance to the Audit Committee on the assurance each Committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees.

Audit Committee

Chair – Peter Aspinall
Lead Director – Alex Farrell

The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation. The outcome of the self-assessment will be reviewed by the Chair of the Committee in liaison with the Lead Director.

Action: Peter Aspinall

The annual report also included a proposal in relation to the Trust's external audit function, which will be considered by the Committee.

Clinical Governance and Clinical Safety Committee
Chair – Bernard Fee
Lead Director – Tim Breedon

The Committee met its Terms of Reference and continued to develop its work programme throughout the year to reflect the risks and objectives of the organisation. Given the current political agenda, the focus of the Committee has shifted to reflect the national agenda, particularly in relation to the Francis Report and other developments, for example, Winterbourne View. The Committee is clear that the issues raised from reports such as these are addressed within the Trust. The focus for the Committee is very much about quality and safety in the coming year. As the Trust enters a difficult trading period, a key area for the Committee will be to monitor and risk assess the impact of CIPs on the quality and safety of services.

Alex Farrell (AF) asked whether development of the Quality Improvement Strategy should feature more strongly in the Committee's terms of reference and both the Chair and Lead Director agreed that it should. AF also asked whether data quality should also feature more in the Committee's work programme, which was supported. Bernard Fee (BF) responded that the challenge for the Trust is to ensure it gets the basics right in terms of data quality and ensuring that it is able to measure what it does.

Action: Committee to review terms of reference and work programme

Mental Health Act Committee
Chair – Helen Wollaston
Lead Director – Tim Breedon

Overall the Committee fulfilled its Terms of Reference and met its work programme. Julie Fox (JF) drew the Committee's attention to five areas.

- The Committee has local authority representation on the Committee at practitioner/manager level. The Chair of the Committee is considering extending this to a more strategic level.
- All Hospital Managers have had a 1:1 review. In other Trusts, Hospital Managers are asked to rate each other, for example, in the way they chair panels, and the Trust may wish to introduce this in the future.
- The Committee continues to review the presentation of data it receives to improve understanding and challenge. The Committee has found data on race and equality in relation to individuals detained under the Mental Health Act useful and, although the numbers are small, it will enable an analysis at the end of the first twelve month period. Tim Breedon (TB) commented that one area for development in the coming year is analysis of the statistics presented, particularly in terms of trends, which will then inform development of the agenda.
- The Committee was inquorate for one meeting and it was suggested that it might be useful to re-consider deputising arrangements for Non-Executive Directors in future, although it was appreciated that the technical nature of the Committee precluded ad-hoc attendance. The Chair of the Committee will also remind members of the importance of attending meetings.

- The Chair has established a series of information giving sessions related to the Mental Health Act at each meeting to look at issues in more depth and to make the Act come alive for Committee members.

BF asked whether there should be a review of the need for two Committees or whether the Clinical Governance and Clinical Safety and Mental Health Act Committees should combine given pressures on time commitments. It was agreed this should be reviewed in more detail and a proposal made to Trust Board. This would include consideration of the comments made by KPMG in its review of corporate governance arrangements.

Action: Dawn Stephenson

Remuneration and Terms of Service Committee
Chair – Ian Black
Lead Director – Alan Davis

The Committee met its terms of reference and fulfilled its work programme for the year. The programme is reviewed regularly by the Chair of the Committee to ensure it reflects the risks and objectives of the organisation and that the Committee adds value. Two areas were highlighted.

- It is likely that there will be an award made in 2013/14 for performance in 2012/13 under the Performance Related Pay scheme.
- The Committee also considers that any issues relating to the timeliness of the circulation of papers has been resolved.

PA invited Deloitte and KPMG to comment. Tim Cutler (TCu) commented that the level of detail was good, reflecting the way Trust Board operates and the process and content compares favourably with other Trusts. The reports show good compliance with terms of reference. He would like to see two areas developed in relation to the impact on how Committees shape and influence Trust Board, and responses to negative comments arising from the self-assessments. The comments were supported by Deloitte.

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

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

AC/13/19 Quality Impact Assessment (agenda item 3)
TB took the Committee through the Quality Impact Assessment process and how the rating of CIPs was agreed. Further work will be undertaken on the process to ensure it is fit for purpose for assessment of risk within the transformational service change

programme. Nisreen Booya (NHB) gave her support for the process and commented on its usefulness for assessing risks engendered by CIPs.

The process and outcome has also been shared with commissioners. The process was supported by BDU Directors although the process was challenging. BF commented that it introduced a healthy and necessary process to assess risk to quality of services arising from CIPs. The Clinical Governance and Clinical Safety Committee will monitor the impact on quality of services and this will also test the robustness of the process.

BF commented that some CIPs will be seen as presenting more risk than others and these are areas where unannounced visits could be focused in the coming year. NHB added that ongoing monitoring will be in conjunction with existing risk processes, such as the weekly risk scan undertaken by the Director of Nursing and Medical Director.

In response to a comment regarding patient/service user challenge to CIPs, TB responded that the process provides an open and transparent rationale for the decisions made. Dawn Stephenson (DS) suggested that the Trust could learn from other models of risk assessment and that it would be helpful if there was a degree of consistency. However, the system has to be transparent, the 'scoring' open and mitigating action considered.

AF commented that the outcome will be incorporated into the quality performance framework to ensure triangulation of performance information to provide an overall picture of assurance to Trust Board.

Paul Hewitt (PH) commented that the process builds on what was in place previously and demonstrates clinical engagement and involvement.

AC/13/20 Minutes and matters arising from the meeting held on 15 January 2013 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 15 January 2013 as a true and accurate record of the meeting. There was one matter arising.

AC/12/64b WYAC internal audit follow up (data quality) (page 1)

IB commented that this action is with Alan Davis, Director of Human Resources, to provide evidence of management of performance strongly and explicitly linked to appraisal and assessment of capabilities and competencies. There is no timescale for this currently as it sits with a longer-term review of pay arrangements within the Trust. IB agreed to update the Committee following the next Remuneration and Terms of Service Committee.

Action: Ian Black

AC/13/21 Internal audit annual plan 2013/14 (agenda item 5)

Clare Partridge (CP) introduced this item. The Committee will approve a final version of the plan on 23 May 2013. CP highlighted a reduction in days for core

operations to reflect the substantial assurance opinion given in 2012/13 in a number of areas. A risk assessment identified two other areas in relation to the Francis Report, and the provider licence and the new risk assessment framework. The Francis Report review would be undertaken across KPMG Trusts and BF asked that this Trust is compared with like Trusts rather than acute. Two workshops were also suggested on the national and local commissioning landscape, and changes to Monitor's regulatory framework. BF also suggested a workshop facilitated by KPMG to gain a better understand of the risks facing the Trust.

AF commented that the plan is risk-based and some areas are included where the Trust knows there is room for improvement, along with areas where the Trust can learn from experience and the knowledge of KPMG from its relationships with other Trusts.

PA questioned why IT systems were medium priority. AF responded that the IM&T Forum assesses risk in relation to IT developments and she will discuss how KPMG can inform this further.

Action: Alex Farrell

KPMG will also introduce feedback forms in 2013/14 to evaluate the service it provides to the Trust.

It was RESOLVED to APPROVE the draft internal audit plan for 2013/14 pending final approval at the meeting on 23 May 2013.

AC/13/22 Review of annual accounts process 2012/13 (agenda item 6)

Annual accounts

PH outlined the risks identified in the audit plan and observations following work completed to date.

- Implications of payment by results.
- Estates rationalisation.
- Delivery of cost improvement programme.
- Revenue recognition.
- Management of override controls.

PH commented that the risks remained relevant and there were no further significant risks to be included. This was supported by the Committee.

The updates to the Annual Reporting Manual were noted. The Committee also noted that the transaction relating to Creative Minds would take the Trust's charitable funds over the threshold for independent examination of the accounts and, as a result, the funds will need a full audit for the year ending 31 March 2013. AF reminded the Committee of the decision at Trust Board in March to move the funds allocated to Creative Minds to the Trust's charitable funds, which does not affect further discussion by Trust Board on the organisational form for Creative Minds in the future.

The Chair and Lead Director will review the document 'Raising the Bar in Audit Committees' for any learning and to inform the work programme for 2013.

Action: Peter Aspinall/Alex Farrell

TB will ensure that the report on Winterbourne View is noted in the Trust's action plan.

Action: Tim Breedon

Deloitte performance against key performance indicators was included in the paper for information and will come back to the Committee for further discussion at the meeting in July 2013.

Action: Deloitte

Quality Accounts

Ellie Cook (EC) took the Committee through the report on the interim audit of mandated indicators. The Trust has selected two indicators out of three relating to delayed transfers of care (DToC) and crisis resolution. Five recommendations were made and all were accepted by management.

- Delayed transfers of care
  - Implement a system to ensure correct DToC dates are recorded by ward staff and that the RiO system can be modified to show delays.
  - Adopt a Trust-wide process for DToC.
  - Adjust the population of Calderdale, Kirklees and Wakefield prior to final re-testing.
  - Ensure the Barnsley population is available at re-testing.

TB commented that the Trust has been quite cautious in its reporting and, therefore, performance will show improvement. He expressed disappointment that clarity on guidance had come so late on DToC. Data has been cleansed and will be available for Deloitte by 22 April 2013 when testing of quarter 4 data begins.

- Crisis resolution
  - Ensure that gatekeeping status is set out clearly in patient notes for future testing.

Karen Batty shared the first draft of the Quality Accounts with Deloitte and Deloitte will provide feedback. A comment was made regarding the lateness of national guidance this year and that all Trusts are now behind in development of the Quality Accounts; however, the Trust is in a good position compared to others.

AC/13/23 Service line reporting and currency development (agenda item 7)

Dawn Gibson (DG) took the Committee through this item.

Service line reporting

PA commented that the next stage is analysis of information; therefore, the Committee would like assurance that the Trust has the necessary training, skills and experience in place within BDUs to make decisions based on the figures as they emerge. AF responded that the process provides transparency and the Trust needs

to understand the variances that emerge between BDUs. The information will be used in the transformational change programme and reviewed formally in monthly performance reviews with BDUs, triangulated with other performance areas; however, the reviews are not just about money and she would be happy to provide a report to the Clinical Governance and Clinical Safety Committee if that would be useful. NHB commented that the outcome may demonstrate the need for more equity between BDUs in terms of contribution to efficiencies and CIPs. Dialogue has begun with commissioners to begin to equalise contribution between BDUs.

PA summarised his feedback to Trust Board that the Committee continues to seek assurance that the Trust understands and can make effective decisions in a granular way to improve its business.

KPMG commented that it considers the Trust is making good progress and will continue to support the Trust in developing service line reporting.

Mental health currency
The report was noted.

AC/13/24 Procurement report (agenda item 8)

Tony Cooper (TCo) took the Committee through his report. He commented that the e-tendering solution will ensure a speedier response for quotes and tenders thus reducing the need for waivers. Procurement actively encourages suppliers to register to increase 'competition' in areas where the Trust is weak currently. There are currently 200 suppliers registered out of 536, which represents 80% of Trust procurement. There will still be a number of areas, such as specialist suppliers, Creative Minds and for continuity reasons, where there will be a single source supplier. Figures for 2012/13 will be used as a benchmark for 2013/14.

Cash releasing CIPs of £200,000 have been factored into the procurement budget for 2013/14.

The eAuction facility will be assessed further.

BF commented that Creative Minds is a significant part of the Trust's business and, therefore, Trust Board needs to be given sufficient time to review its structure and how it operates in future before making a decision on its organisational form.

AC/13/25 Treasury management update (agenda item 9)

Rob Adamson (RA) reminded the Committee that the calculation methodology for Public Dividend Capital (PDC) in 2013/14 has changed. The payment is currently calculated as 3.5% of average net relevant assets using opening/closing values to calculate the average. In practice, this means that surplus cash can be invested in other institutions throughout the financial year and the Trust has used this to maximise returns. The monies are returned to the Government Banking Service on the last day of the financial year so it can be used to calculate the PDC payment. This ensures that the PDC charge is as low as possible. For 2012/13, the PDC payment is calculated as £1.7 million. This is common practice across foundation

trusts; however, it causes major fluctuations (estimated as £1.8 billion) within the Government Banking Service.

There has, therefore, been a change to the calculation in that an average cash balance will be adopted. To minimise the 3.5% charge, cash will have to remain within the Government Banking Service to allow it be deducted from the calculation. In doing so, this will attract a lower interest rate, currently at 0.25% per annum, which equates to approximately £65,000 per annum interest received but will be dependent on the Trust's cash position throughout the month. This is approximately 50% less than the estimated interest available from commercial providers based on current rates. A review of the Trust's Treasury Management Policy is required and this will be submitted to Trust Board in July 2013 for approval, following consideration by the Committee. This will include a review of the working capital facility, the continued need for such a facility and at what level.

Action: Alex Farrell

RA also highlighted the change to the risk assessment framework, which will have implications for the Trust when it starts spending its cash on capital for estates development. This will be part of the sensitivity analysis in the Integrated Business Plan. BF commented that any increase in monitoring if the Trust's financial risk rating worsens as a result of these changes must not make the Trust risk averse or change its approach.

JF asked if the Trust could challenge the change to treatment of cash balances as foundation trusts are supposed to be autonomous. AF responded that any challenge would come through the Foundation Trust Network. BF expressed caution in what the Trust chooses to formally challenge; however, JF asked that the Trust raises the issue.

Action: Alex Farrell

It was RESOLVED to APPROVE the proposals to:

- **monitor the Trust's investment of cash in 2013/14;**
- **review the Trust's working capital facility alongside the capital programme.**

AC/13/26 Internal audit progress report (agenda item 10)

Eleven audit reports were completed and presented to the Committee.

- Clinical governance – substantial assurance.
- Compliance: CQC standards – moderate assurance.
- Quality governance framework – substantial assurance.
- Change management programme – moderate assurance.
- Health records (SystmOne) – moderate assurance
- Adult safeguarding – limited assurance.
- IG Toolkit, including follow up – substantial assurance.
- Support services review: facilities – moderate assurance.
- Medical re-validation – substantial assurance.
- Stewardship of financial affairs of community patients follow up – limited progress.
- Commercial strategy – advisory (no opinion given).

The outcome of the estates investigation will be reported to the Committee in July 2013.

Action: KPMG

Change management programme

BF asked for more clarity for Trust Board on how the programme is managed overall. AF responded that this was on the agenda for Trust Board in April and, if not clear, it should be brought back to the Committee for further discussion.

Action: Alex Farrell

Health records management

The Committee noted the triangulation between this report and that for clinical audit where there was a recommendation regarding follow up action, which is reflected in this report. BF asked for this to be considered at the Clinical Governance and Clinical Safety Committee next week.

Action: Bernard Fee

NHB expressed nervousness around the substantial opinion given to the clinical audit review. PA responded that the Committee should take assurance from 'green' reports; however, there is no room for complacency. TCu added that, if individual reports indicate a different opinion with another internal audit report, then KPMG would review the original assumptions.

Safeguarding adults

DS commented that there is a piece of work in place to address the concerns in relation to CRB checks with a clear process, which can be shared with KPMG.

Action: Dawn Stephenson (for Alan Davis)

AF added that this had been picked up in the TCS transfer and work has been undertaken in 2012/13; however, it was a more complex process than originally envisaged and has, therefore, taken longer than originally planned. PA asked if there was anything to learn from this. AF responded that, in future, interim timescales should be established for any action with long timescales to enable robust monitoring.

Facilities management: value for money

TCo confirmed that a task and finish group has been set up to review expenditure with facilities and utilisation of the e-tendering system to drive out value for money. BF asked why there were still two structures in place and AF confirmed this is under review by Alan Davis. BF added that he would also like to see the Trust look at how it can deliver more efficiently and effectively in this area, which does not have a direct impact on delivery of front-line services. It was agreed this should be followed up during 2013/14 by the Committee.

Action: Peter Aspinall (for consideration at agenda setting)

BF made a plea for a reduction in the number of papers circulated to the Committee. AF confirmed that, from July 2013, a summary of full, substantial and moderate opinion reports would be included within KPMG's update and full reports circulated for limited or no assurance opinions only. It was suggested that advisory reports

could be circulated by email and a summary of the key findings brought to the Committee; however, AF would like this to be reviewed on a case-by-case basis.

The follow up report and technical update were noted.

AC/13/27 Counter fraud progress report (agenda item 11)
Karen Sharrocks (KS) took the Committee through the report. The counter fraud annual report will be presented to the July meeting, which will include information on the replacement for the qualitative assessment for 2012/13.

PA commented that the Trust has an ambitious sickness target and he asked for assurance that there is no correlation between sickness absence and staff working whilst absent in secondary employment. KS responded that the Committee could take assurance from the processes in place and staff are encouraged to report concerns as they arise. She confirmed that the Trust has the resources in place to address this concern.

The Committee also RESOLVED to APPROVE the counter fraud plan for 2013/14.

AC/13/28 External audit update (agenda item 12)
This was covered under agenda item 6.

AC/13/29 Triangulation of risk, performance and governance (agenda item 13)
The report was noted by the Committee.

AC/13/30 Losses and special payments report (agenda item 14)
The report included an analysis of expenditure and it was noted that there were no trends or themes to report. The report was noted.

AC/13/31 Date of next meeting (agenda item 15)
The next meeting will be held on Thursday 23 May 2013 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield. This is an additional meeting to approve the annual report, annual accounts and Quality Accounts. The next full meeting will be held on Tuesday 9 July 2013 at 14:00 in the boardroom, Kendray Hospital, Doncaster Road, Barnsley.

AC/13/32 Any other business (agenda item 16)
No other business was raised.

Minutes of Audit Committee held on 9 April 2013
Private session

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
Apologies:	Jonathan Jones	Non-Executive Director
In attendance:	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Alex Farrell	Deputy Chief Executive/Director of Finance

AC/13/33 Appointment of external auditors

As set out in the annual report, overall service levels received from Deloitte and client management has been rated as 'very good. Based on a recent tender evaluation for professional services, the external audit fee represents good value for money. It was suggested that the recommendation to the Members' Council should be to extend Deloitte's contract for one year and repeat the tender exercise in 2014/15. The Head of Procurement has confirmed that there was an option in the original tender to re-appoint Deloitte for up to two years; however, Deloitte would need to be included in the new Government procurement framework. It was noted that it would be unlikely for Deloitte to be excluded.

Bernard Fee (BF) commented that, if Deloitte are providing a reasonable service and the fees are reasonable, then it would seem to be a waste of resources to go out to tender. Alex Farrell (AF) responded that she would need to test the future fee level with Deloitte as well as continuity of individuals assigned to the Trust.

It was agreed to request from Deloitte a quote for an extension to the current contract for both one and two years and circulate to Committee members.

Action: Alex Farrell

The outcome of the exercise would be reported to the Members' Council in July 2013 as support for a request to extend the contract with Deloitte.

AF will also raise with Deloitte a number of areas which were identified and offered in the original bid and agree how the Trust could make use of these services.

Action: Alex Farrell

It was also agreed to seek the support of Michael Smith, publicly elected governor for Calderdale, who was involved in the original tender exercise, and Peter Aspinall (PA) agreed to contact him.

Action: Peter Aspinall

Subject to a satisfactory outcome of the above actions, **it was RESOLVED to APPROVE the proposal to seek the Members' Council approval for an extension to the current contract with Deloitte for a period of one or two years.**

Minutes of Audit Committee held on 23 May 2013

Present:	Peter Aspinall	Chair of the Committee
	Jonathan Jones	Non-Executive Director
Apologies:	Members	
	Bernard Fee	Non-Executive Director
	Others	
	Tim Cutler	Head of Internal Audit, KPMG
In attendance:	Robert Adamson	Head of Finance
	Susan Baines	Head of Financial Accounting
	Ian Black	Chair of the Trust
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Ellie Cook	Manager, Deloitte
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Dawn Gibson	Deputy Director of Finance
	Paul Hewitson	Senior Audit Manager, Deloitte
	Steven Michael	Chief Executive
	Clare Partridge	Senior Manager, KPMG
	Dawn Stephenson	Director of Corporate Development
	Paul Thomson	Partner, Deloitte
	Helen Wollaston	Non-Executive Director

AC/13/34 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (PA) welcomed everyone to the meeting. The apologies were noted.

AC/13/35 Minutes and matters arising from the meeting held on 9 April 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 9 April 2013 as a true and accurate record of the meeting. Matters arising will be taken at July's meeting.

AC/13/36 Annual accounts 2012/13 (agenda item 3)

Item 3.1 Report from the Director of Finance

PA invited Alex Farrell (AF) to introduce her report on the accounts. She began by saying that the year had seen a good financial performance and highlighted the following points.

- The Trust has exceeded its financial surplus target.
- The Trust has exceeded its financial risk rating.
- The Trust did not achieve its capital spend target.
-

Paul Thomson (PT) alerted the Committee that, under Monitor's revised calculation for the financial risk rating, Trusts who are more than 25% away from the capital spend target will be a cause for concern. AF assured the Committee that the Trust monitors its performance on a monthly basis.

It was RESOLVED to RECEIVE the report from the Director of Finance.

Item 3.2 Head of Internal Audit Opinion 2012/13
The overall opinion given was one of significant assurance that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the Trust's objectives, and controls are generally being applied consistently.

It was RESOLVED to NOTE the Head of Internal Audit Opinion.

Item 3.3 ISA 260 Audit of Accounts 2012/13 (report to those charged with governance)
PT introduced this item and commented on a very good audit process. He thanked the finance team and also commented on the good quality of the working papers. Deloitte was able to issue an unmodified financial statement audit opinion.

PT confirmed that the provisions included in the accounts, particularly around redundancies, satisfactorily meet accounting tests across 2013/14 and 2014/15. Issues that other Trusts experienced have not affected this Trust and Deloitte was satisfied with the Trust's approach. There was one minor adjustment relating to an incorrect classification of a fixed asset and this was the best across the Trusts Deloitte audits. Deloitte testing on significant risks has not identified any material adjustments to the accounts. The professional fees earned by Deloitte were noted. Ian Black (IB) commented that Deloitte's non-audit fees were greater that its fees for audit functions. The explanation given by Deloitte was noted and accepted by the Committee. It was stressed that the non-audit functions were delivered by entirely separate teams to the audit function.

Item 3.4 Letter of Representation
AF commented that the Letter, signed by the Accounting Officer, gives assurance to Deloitte on the information provided during the audit. Paul Hewitson (PH) confirmed there were no non-standard issues included in the Letter.

It was RESOLVED to APPROVE the Letter of Representation.

Item 3.5 Annual accounts 2012/13
Rob Adamson (RA) outlined two changes made to the accounts.

- On page 20, a payment relating to MARS, which was previously showing as redundancy, has moved to 'other departures'.
- An additional table has been included on page 18 to show staff who have been paid more than £100,000 per annum in 2012/13 and in comparison with 2011/12. This is not a mandatory disclosure but has been included at the request of the Chair to demonstrate openness and transparency.

It was RESOLVED to APPROVE both changes to the Accounts.

IB commented that, on page 19, the number of days lost to sickness absence does not seem to reflect staff numbers. The information is provided by the Department of Health and the Committee noted the explanation given. It was agreed to include an additional line of explanation in the Note.

RA explained that the Trust uses a consistent format for the remuneration report to enable comparison with other Trusts and with other years. Performance related pay was not paid in 2012/13 but has been accrued for payment in 2013/14 in relation to the 2012/13 scheme. AF suggested inclusion of an additional Note that the Trust does have a scheme, and that no payment was made in 2012/13; however, a sum has been accrued for 2012/13 for payment in 2013/14. Any payments made under the scheme are non-consolidated and non-pensionable.

AF confirmed that the checks undertaken show the accounts reflect the FT consolidated schedules and it was agreed that the Committee would take the assurance of the Director of Finance in future years.

It was RESOLVED to APPROVE the accounts for 2012/13, subject to the inclusion of two additional notes as set out above.

AC/13/37 Approval of the annual report 2012/13 (agenda item 4)
It was RESOLVED to APPROVE the annual report and the Annual Governance Statement for 2012/13.

AC/13/38 Approval of the Quality Report 2012/13 (agenda item 5)
Tim Breedon (TB) introduced the Report, which was developed through engagement with service users and carers, the Members' Council and partners. The Report built on advice in previous years and to make it accessible and meaningful in terms of reporting on quality within the constraints of Monitor's guidance.

PT confirmed that the content of the Report meets Monitor's Annual Reporting Manual, that the content is consistent with other information sources, and that data testing has been carried out. He confirmed that this was a high quality document and was in the top two/three of documents Deloitte has seen during the audit.

Ellie Cook (EC) outlined the findings of the data testing undertaken on delayed transfers of care, access to crisis resolution teams and incidents resulting in severe harm or death. In relation to this last indicator, the Trust captures information in a slightly different way to that required by Monitor; therefore, Deloitte was unable to extract the necessary information directly from Trust data. The Trust's system pre-dates that of the National Reporting and Learning System (NRLS) and there has been no mandate centrally for Trusts to change the way data is captured. Deloitte has recommended that the Trust has a specific field on DATIX to categorise incidents against NRLS categories as well as its existing approach. It was stressed that the finding was in relation to data testing and raised no concerns about patient safety within the Trust.

TB commented that there is a concern that Monitor will mandate this indicator for future years. PT confirmed that feedback to Monitor will be that it has provided Trusts with difficulties, which is likely to lead to a further review by Monitor before a final decision is made. CP supported Deloitte's approach as KPMG's feedback to Monitor is that auditors would find it extremely difficult to provide an audit opinion as the indicator currently stands. The Chief Executive (SM) responded that, if the

indicator is mandated, then the Trust will comply with the requirements. PT also suggested that what is reported and at what level is reviewed, particularly to Trust Board. IB asked that both matters are considered by the Clinical Governance and Clinical Safety Committee and then Trust Board in July. The Committee also understood that the Report from Deloitte would be a public document as it will be presented to the Members' Council in July.

It was RESOLVED to APPROVE the quality report for 2012/13.

AC/13/39 Internal audit annual report 2012/13 and annual plan 2013/14 (agenda item 6)

CP introduced the annual report for 2012/13. Twenty-one reviews were completed resulting in 101 recommendations. All were accepted by management. The Head of Internal Audit Opinion was one of substantial assurance, which reflects core processes receiving substantial assurance throughout the year. Where limited assurance opinions have been given, these have tended to be in high risk areas which are not reflected in systems of internal control. Information on the implementation of recommendations is included in the internal audit progress report to each Audit Committee meeting.

It was RESOLVED to NOTE the internal audit annual report for 2012/13.

The annual plan updated the one presented to the Committee in April 2013 following further input from the Trust.

It was RESOLVED to APPROVE the internal audit annual plan for 2013/14.

On behalf of the Committee, PA thanked Trust staff involved in the production of the annual accounts, report and quality report and to external and internal audit for the level of partnership working.

AC/13/40 Any other business (agenda item 7)

No other business was raised.

AC/13/41 Date of next meeting (agenda item 8)

The next meeting will be held on Tuesday 9 July 2013 at 14:00 in the boardroom, Kendray Hospital, Doncaster Road, Barnsley.

Minutes of Clinical Governance and Clinical Safety Committee held on 16 April 2013

Present:	Bernard Fee	Non-Executive Director (Chair)
	Helen Wollaston	Deputy Chair of the Trust
	Nisreen Booya	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:	Julie Fox	Non-Executive Director
In attendance:	Seri Abraham	Consultant, Ward 19, Priestley Unit (item 10)
	Karen Batty	Practice Governance Lead (item 4)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance

CG/13/20 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (BF) welcomed everyone to the meeting. The apology was noted.

CG/13/21 Minutes of the previous meeting held on 12 February 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Clinical Governance and Clinical Safety Committee meeting held on 12 February 2013.

CG/13/22 Matters arising (agenda item 3)

There were three matters arising.

CG/12/34 Medicines management internal audit (item 3.1)

Tim Breedon (TB) confirmed that a re-audit would take place early in 2014, which provides sufficient time to embed the actions arising from the recommendations made by internal audit. TB will bring an update on the progress to devolve pharmacy services into Business Delivery Units (BDUs) to the June meeting. BF asked that this includes consideration of any additional resource required to ensure implementation is effective. TB and Nisreen Booya (NHB) confirmed that this is not likely to be the case.

Action: Tim Breedon

CG/13/12 Clinical audit internal audit (item 3.2)

An issue was raised by NHB at the Audit Committee on 9 April 2013 regarding the substantial assurance opinion given to clinical audit by internal audit. The concerns were noted and the Committee reiterated its wish that clinical audit remains a priority for the Trust. Karen Batty (KB) confirmed that a review of capacity, systems and processes will be undertaken before an assessment of whether additional resources are required. TB will bring an update paper back to the Committee in November 2013.

Action: Tim Breedon

CG/13/17 Managing aggression and violence in children's and adolescents' mental health services (CAMHS) (item 3.3)

The Trust has no in-patient services for CAMHS. Therefore, the focus is on 'break away' skills and the training emphasises a proportionate response. The Managing Aggression and Violence (MAV) Team can offer bespoke advice and training around a particular individual should the need arise. The position would change if the Trust provided Tier 4 services.

CG/13/23 Quality Accounts 2012/13 (agenda item 4)

The consultation on quality priorities has confirmed that the current seven priorities should remain in place for a further year with a revised focus. The key performance indicators (KPIs) will be revised to meet the new focus areas. KB is working with Deloitte on an improved approach to measure progress in 2013/14. It was agreed that detailed decisions on how and what the Trust measures and how this should be resourced should be agreed through the Executive Management Team (EMT). Helen Wollaston (HW) asked that there is a balance with outcomes and the impact the Trust has made not just reporting of performance against KPIs.

Action: Tim Breedon

KB updated the Committee on the outcome of the Deloitte interim audit of the two mandated indicators (gatekept admissions and delayed transfers of care (DToC)) and explained the reporting issues identified by Deloitte on DToC. The data has been re-validated and guidance re-issued to BDUs. Deloitte will re-audit the data next week. The current performance figure is 3.92%, which is below the 7.5% target set by Monitor. The Trust has reported the issue to Monitor and has stressed that this is an issue with recording not quality.

The third mandated patient safety indicator (number of patient safety incidents reported against number of serious incidents) will also be audited by Deloitte and red and amber incidents reviewed to assess whether they have been correctly graded.

In terms of format and presentation, KB has been working closely with Deloitte. A document will be prepared for circulation to stakeholders for the 30-day consultation process. BF asked that Committee members flag up any concerns prior to the preparation of a final draft for the meeting on 7 May 2013. HW expressed a concern that Barnsley continues to be separate in the report. It was accepted that this is likely to continue as there are different commissioning arrangements for Barnsley, setting different quality parameters; however, the quality priorities are the same across the Trust, including Barnsley. It was suggested that some narrative is included in the report to reflect this.

Action: Karen Batty

BF commented that he would like to see continuity of lead officer next year to build on the developments and progress made this year.

Action: Tim Breedon

CG/13/24 Quality Governance Framework (agenda item 5)

The report and outcome of the review by internal audit was noted by the Committee. This will be included in a fuller report to Trust Board in the Corporate Governance Statement at the end of April 2013. Three areas were highlighted for attention:

- the format of BDU minutes;
- the need for regular skills assessment for Trust Board; and
- appraisal completion.

CG/13/25 Serious incidents report (agenda item 6)

TB reported that the end-of-year position is broadly similar to previous years. The annual report will be presented to the Committee in June 2013.

TB highlighted an issue with reporting of SIs into the new commissioning arrangements as governance arrangements are unclear. Clarity is being actively sought.

CG/13/26 Health and safety – outcome and action plan arising out of peer review (agenda item 7)

There are four actions arising from the review to be completed by 1 June 2013:

- establish a single health and safety team;
- establish a single emergency planning and security team;
- produce an integrated health and safety annual report; and
- produce an integrated health and safety plan for 2013/14.

The annual report and plan will be presented to the Committee at the June 2013 meeting.

Action: Alan Davis

The external exercise to test the Trust's emergency arrangements will be delayed whilst the team is set-up and pending confirmation of regional arrangements. Alan Davis (AGD) was asked to advise when this would be. The Chair's concerns regarding the delay in the testing were noted.

Action: Alan Davis

AGD will discuss a repeat audit of health and safety with KPMG in terms of inclusion in its plan for 2013/14.

Action: Alan Davis

CG/13/27 Incident Review Panel (agenda item 8)

The Committee noted the revised terms of reference, which will strengthen the organisational overview of the incident review, action planning and learning process to improve patient safety and provide assurance to the Committee on the performance management of the SI review process, associated learning, and subsequent impact within the organisation. The group will work closely with the Clinical Reference Group, which looks at how lessons can be learned from incidents.

CG/13/28 Sub-groups (agenda item 9)
The following issues were highlighted.

- The staff opinion survey has shown a dip in health and safety training and this will feature in the action plan.
- The Health and Safety Executive visited Kendray as part of its prioritised review programme of construction and building sites. The visit went well and positive feedback was received on health and safety arrangements.
- Infection prevention and control – staffing issues have been resolved.
- Safeguarding – a cross-Trust safeguarding forum has been set up to cover children's and adults' safeguarding issues.
- Any seclusion over 72 hours is now automatically reported to the MAV Team to provide advice and guidance.

CG/13/29 Suicide audit (agenda item 10)
Dr Abraham took the Committee through the findings from the audit. The conclusions were as follows.

- Referral: need for uniformity.
- Access to services: improve information gathering and documentation.
- Interface: improve information sharing.
- Medics intervention: better diagnosis, prescribing issues, collateral information gathering and care planning.
- Improve carer information on RiO.
- Consider mental health act assessment if appropriate.
- Improve quality of risk assessments.
- Consider National Confidential Inquiry information during assessments.

BF commented on the honesty and openness with which the findings were presented and which were received in a spirit of learning not blame. The conclusions also demonstrate the importance of recording on RiO.

Next steps
- TB/NHB will review the conclusions linked to a workshop to agree the Trust's approach to suicide prevention.
- The Committee will receive the response and action plan in June 2013.
- The plan will be monitored on an ongoing basis as a tool to ensure improvement in practice.
- BF will feedback to Trust Board on the conclusions within the context of the audit.

Action: Tim Breedon/Nisreen Booya/Bernard Fee

CG/13/30 Action plans arising from the Francis Report and Winterbourne View (agenda item 11)
Francis Report
A workshop will be held on 26 April 2013 to undertake a gap analysis and develop an action plan, which will be presented to the Committee and Trust Board in June 2013.

Action: Tim Breedon

A report to the Members' Council on 1 May 2013 includes recommendations specific to foundation trust governors and governors will be asked to agree how they want to take these recommendations forward.

Winterbourne View

The action plan was noted. An update on the action plan will be provided on a regular basis. Key issues for the Trust are:

- CQUINs; and
- offer to commissioners for assessment of service users placed out-of-area.

Action: Tim Breedon

CG/13/31 Unannounced visits (agenda item 12)

The action plan presented demonstrates the seriousness with which BDUs have taken the recommendations and developed action plans to address the issues raised. BF asked how the Trust will demonstrate that actions have been implemented. TB responded that Practice Governance Coaches will work with governance groups within BDUs to 'close' actions. BF suggested that Committee members undertake return visits to check actions have been implemented on a sample/random basis.

Action: Karen Holland

AGD commented that return visits will also demonstrate any cultural change in relation to management of wards. HW also asked for a further analysis of responses in relation to advocacy services and it was agreed to feed this back into the Mental Health Act Committee as part of the action identified following the presentation on advocacy services in February 2013.

Action: Tim Breedon

BF asked that the unannounced visits retain a degree of informality and that the process does not become too bureaucratic. The appropriateness of involvement of the Members' Council should also be considered.

Action: Tim Breedon

CG/13/32 Quality impact assessment (agenda item 13)

TB outlined the process undertaken as part of the 2013/14 annual planning and budget setting process. TB will ensure a summary of the outcomes is circulated to the Committee.

Action: Tim Breedon

It was suggested that the next round of unannounced visits could focus on the areas where cost improvements were perceived to be riskier than others.

Action: Tim Breedon/Karen Holland

CG/13/33 Barnsley OfSTED action plan (agenda item 14)

There were no issues to report against implementation of the action plan. Some timescales have changed but this has been with the approval of the overarching project board and the Trust is meeting these.

CG/13/34 CQC registration self-assessment Q3 2012/13 (agenda item 15)
The report was noted by the Committee. No significant risks were flagged as a result of the self-assessment.

CG/13/35 External review 2010/12972 (agenda item 16)
A final draft report has been received and the Chair, Chief Executive, Director of Nursing and the Medical Director will approve the report on behalf of Trust Board under the delegated authority agreed in January 2013.

Action: Tim Breedon

CG/13/36 Annual reports (agenda item 17)
Information governance (item 17.1)
The annual report was noted.

CG/13/37 Any risks not previously covered (agenda item 18) and Issues to bring to the attention of Trust Board (agenda item 19)
TB raised two issues.

- TB/NHB will meet with the Director of Nursing, Medical Director and Chief Operating Office at Mid-Yorkshire Hospitals NHS Trust to take forward a joint response to the recommendations in the Rule 43 Letter.
- The CQC has been notified of the SI at the Bretton Centre and the Trust will continue to work with the CQC as the investigation progresses. The investigation will take place as soon as possible with a report within the usual twelve-week timescales.

CG/13/38 Date of next meeting (agenda item 20)
The next meeting will be held on Tuesday 7 May 2013 at 11:30 in Room 40, Ground Floor, Large Mill, Folly Hall, Huddersfield. This meeting is an additional meeting to approve the Quality Accounts for 2012/13. The next scheduled meeting will be held on Tuesday 11 June 2013 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield.

Minutes of Clinical Governance and Clinical Safety Committee held on 7 May 2013

Present:	Bernard Fee	Non-Executive Director (Chair)
	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust
	Nisreen Booya	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:	None	
In attendance:	Peter Aspinall	Non-Executive Director
	Karen Batty	Practice Governance Lead
	Ian Black	Chair of the Trust
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Steven Michael	Chief Executive
	Karen Taylor	Director of Service Development and Improvement

CG/13/39 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (BF) welcomed everyone to the meeting. There were no apologies.

CG/13/40 Approval of Quality Accounts 2012/13 (agenda item 2)

Tim Breedon (TB) introduced the document, which is the third iteration of a technical document, prescribed in content by guidance from the Department of Health and Monitor. It is not intended as a comprehensive document outlining the Trust's approach to quality. This will be set out in the Quality Improvement Strategy, which will be presented to Trust Board. Deloitte is supportive of the approach the Trust has taken and of the document developed to date seeing it as accessible in style and format, meeting Monitor requirements and articulating progress on last year.

BF commented that Deloitte had been very supportive in the audit of the quality indicators although less so on engagement and guidance on the format and style of the document. Therefore, Deloitte will be able to retain a critical stance on the end product.

<u>Enhancements and changes</u>
The following were suggested.

- An explanation for quality priorities (key measures of performance 2012/13) rated red will be given in the narrative.
- It was agreed to change the clustering rating to amber to reflect the actual achievement and a built-in tolerance; however, it was agreed to leave sickness as red and include month 12 performance figures.
- Under quality priorities, it was agreed to provide an explanation of how/where performance will be measured.
- An explanatory note on the Clostridium Difficile target will be included.

Mapping across to Monitor requirements

TB took the Committee through the Monitor requirements and where these are included in the Quality Accounts. The Committee was satisfied that the content met the requirements.

Detailed review

The following were suggested on a detailed review of the document.

- There needs to be a link of the strapline on the cover to the Trust's values. "Improve and be outstanding" was agreed.
- It was suggested that use of the Trust's full name in the document is reviewed.
- The Committee asked that an explanation of abbreviations, acronyms and NHS-related terms are included (applies to both the current version and the public document).
- It was agreed to retain both the Chair and Chief Executive's statements.
- Peter Aspinall (PA) asked how the Trust achieved continuity in terms of priorities. TB responded that the priorities give sufficient flexibility for the Trust to focus or emphasise different aspects from year-to-year and demonstrates continuity in terms of areas that are important to the Trust. It also enables the Trust to stretch targets year-on-year.
- The Committee asked for inclusion of an explanation of why Barnsley targets are different.
- It also asked for an explanation of the NHS Safety Thermometer.
- Priority 1 under the 'What Next' section is to be enhanced and include confirmation that the priorities will continue through the service transformation programme.
- The Committee asked for commentary on the performance and goals under priority 2.
- Reference to equality and diversity in relation to priorities was also requested.
- Across all priorities, it should be explicit what services the target applies to as there was some confusion as to whether these were Trust-wide or just mental health.
- The Committee asked that the concerns regarding care planning are made explicit in the narrative.
- An explanation of clustering at the beginning of the document was requested, preferably at the point it first appears.
- The Committee asked for an explanation of why clinical record keeping and communication between teams, both internally and externally, is important.
- More explanation in priority 6 of why appraisal and sickness management are important measures.
- The health and safety training figure requires further explanation.
- Achievement of NHS LARMS at level 1 needs to be further explained under priority 7 as well as NICE guidance.
- The Committee asked that 'gatekept' is explained under priorities for 2013/14.
- The CQUIN table needed an explanation for the loss of £750,000 and non-achievement of targets.

The Committee also asked for more 'so what' to be included in the narrative to explain where the Trust will focus its efforts in 2013/14. It was suggested that this could be done by using the 'what next' narrative under each priority.

Subject to the changes requested, **it was RESOLVED to APPROVE the Quality Accounts 2012/13 for presentation to the Audit Committee on 23 May 2013.**

CG/13/41 Date of next meeting (agenda item 3)

The next meeting will be held on Tuesday 11 June 2013 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield.

Minutes of the Mental Health Act Committee Meeting held on 7 May 2013

Present:	Julie Fox	Non-Executive Director
	Helen Wollaston	Non-Executive Director (Chair)
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
In attendance:	Peter Aspinall	Non-Executive Director
	Kyra Ayre	Acting Head of Service, Mental Health and Assessment and Care Management (Barnsley) – local authority representative
	Julie Carr	Mental Health Act/Mental Capacity Act Manager
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Yvonne French	Assistant Director, Legal Services
	Paul Gillespie	Workforce Development (Wakefield) – local authority representative
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
	June Stokes	Independent Associate Hospital Manager
	Phalaksh Walishetty	Consultant, Calderdale (adult services) (for item 4)
Apologies:	**Members**	
	Jonathan Jones	Non-Executive Director
	Attendees	
	Ian Noble	Mental Health Act/CPA Lead (Barnsley)
	Antonios Lakidis	Associate Specialist, Calderdale
	Craig Limbert	Seconded AMHP manager (Kirklees) – local authority representative (part)

MHAC/13/10 Welcome, introduction and apologies (agenda item 1)

Helen Wollaston (HW) welcomed everyone to the meeting and the apologies, as above, were noted. She explained the new format of the meeting to provide a better understanding of the practical application of the Mental Health Act within the Trust.

MHAC/13/11 Minutes of the previous meeting held on 5 February 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes from the meeting held on 5 February 2013.

MHAC/13/12 Matters arising from the previous meeting (agenda item 3)

There were four matters arising.

MHAC/12/29a Advocacy services

Commissioning of advocacy services moved to local authorities from 1 April 2013 and are provided by VoiceAbility in Wakefield and Barnsley, Cloverleaf in Kirklees and Rethink in Calderdale. Yvonne French (YF) confirmed that leaflets and posters are available for ward staff and for display on wards across the Trust. All patients on Community Treatment Orders (CTOs) are sent information on advocacy services and relevant care co-ordinators are asked to confirm that patients have been informed of their rights.

Statistics have been provided by Cloverleaf in Kirklees (as agreed at the last meeting) and these will be brought to the next meeting.

Action: Yvonne French

In terms of feedback from dialogue groups, there are a number of workshops in June/July to review the Involving People Strategy, which will include feedback and views on advocacy services. Dawn Stephenson (DS) will feedback to the next meeting.

Action: Dawn Stephenson

Julie Fox (JF) asked whether the Trust's view of advocacy services would be sought by local authorities. Tim Breedon (TB) responded that the Trust has been asked in the past at renewal time and JF suggested that the Trust is proactive in sharing feedback following the workshops in June/July. It would also offer the opportunity to ask for performance statistics from each provider.

Action: Tim Breedon

MHAC/13/04 Ethnicity monitoring

YF reported that the performance and information team has advised that the codes used are nationally-used codes and there is no flexibility in the system to add additional codes. It is mandatory to complete the box on RiO; however, it does allow for a 'don't know' or 'unknown' to enable a patient to be admitted. The issue will be raised at the Data Quality Steering Group to ensure clinicians return to RiO to complete the data.

Action: Tim Breedon

JF asked that reporting categories are raised with the Department of Health as the issue of people of Eastern European origin entering services cannot just be one for this Trust.

Action: Yvonne French

MHAC/13/06 Community Treatment Orders audit

YF reported that an audit tool has been developed and the outcome of the re-audit will be reported to the Committee in February 2014.

Action: Yvonne French

MHAC/13/06 Tribunal Services

A review of the facilities used by Tribunal Services was undertaken by the Trust's estates team and concluded that, wherever practically possible, the Trust meets the expectations of the Code of Conduct; however, extra requirements, such as parking, toilets and separation of areas, were not included and these need to be followed up.

Action: Tim Breedon

MHAC/13/13 The Act in practice – compliance and assurance pathway/community assessment and admission pathway (agenda item 4)

Dr. Walishetty gave a presentation on the community assessment and admission pathway. One issue raised related to conveyancing by the ambulance service. It was suggested that the Director of Nursing and the Medical Director meet with their equivalents at the Yorkshire Ambulance Service to agree a policy.

Action: Tim Breedon/Nisreen Booya

It was suggested that the work started to develop a protocol with the ambulance service should be followed up.

Action: Ian Priddey

It was also suggested to raise the issue in the S136 Group and the Mental Health Act Chairs Group.

Action: Helen Wollaston

MHAC/13/14 The Act in practice – Legal update (agenda item 5)

The three briefing notes on 'Next of kin and nearest relative', 'Applying for Deprivation of Liberty authorisation', and 'How long can a patient be held under S136?' were noted.

MHAC/13/15 Audit and compliance reports (agenda item 6)

CQC Mental Health Act annual report action plan

The Trust has reviewed the 49 recommendations and provided a 'RAG' rating against each. Of the recommendations, 28 are rated green and 20 rated amber. These will be addressed in the next two months and an update will come to the Committee in August 2013.

Action: Yvonne French

There is one red recommendation relating to the lack of a multi-agency conveyance protocol for patients subject to the Mental Health Act.

Section 17 leave audit

The audit was undertaken using the same took as the previous audit. There has been a degree of improvement; however, not to the level expected. The three recommendations were supported and it was agreed that TB would take the report into the Executive Management Team.

Action: Tim Breedon

Nisreen Booya (NHB) suggested inviting Julie Carr (JC) to the Acute In-Patient Consultants' Forum to make a presentation.

Action: Julie Carr

It was also agreed to review the forms used so printed instructions are on the pad and consider use of electronic forms.

Action: Yvonne French

Cancellation of leave audit

It was agreed to undertake a re-audit at the latter end of 2013 with a report to the meeting in February 2014.

Action: Yvonne French

MHAC/13/16 Care Quality Commission visits (agenda item 7)

Thornhill Unit, Bretton Centre

YF confirmed that work is underway with performance and information to utilise electronic recording for S132 on RiO.

Ashdale, the Dales

The Committee expressed a degree of disquiet regarding the length of time the recommendation to complete Action 3 (installation of an external intercom) has taken to progress. YF agreed to take forward and to escalate to Director level if necessary.

Action: Yvonne French

The report and action plan for Enfield Down was noted.

MHAC/13/17 Monitoring Information (January to March 2013) (agenda item 8)

Ethnicity (paper 1)

Peter Aspinall (PA) asked where the disparity in detention was reviewed and HW clarified that the Committee undertakes the formal review. The Committee will look at figures at the end of the year to review trends rather than individual quarters where the numbers are so small. She confirmed this is a national issue. This will be reviewed at the next meeting and 'spikes' and trends identified. HW asked for the national figures from the CQC to be included as well as Trust totals and data by locality.

Action: Yvonne French

Hospital Managers' appeals cancelled for other reasons (paper 5a)

YF reported that 'patient had review by Tribunal' as a reason for cancellation only occurs in Barnsley and she will ask for a review of why this is so.

Action: Yvonne French

Local authority monitoring information

The information was noted. Ian Priddey (IP) explained the reasons behind the elderly patient who refused conveyance to hospital.

Kyra Ayre (KA) was asked to review inclusion of data for 'no application made by AMHP' in Barnsley.

Action: Kyra Ayre

MHAC/13/18 Issues arising (agenda item 9)

Hospital Managers' Forum notes 26 February 2013

No issues were raised.

Local authority update

In Wakefield, there are four trainee AMHPs (all social workers) to maintain numbers.
In Barnsley, there are two trainees; however, the local authority is losing more than adding although the numbers are technically sufficient.
In Calderdale, the numbers are being maintained but there is no slack in the system.
All confirmed there had been no reduction in AMHPs due to local authority cuts.

It was understood that there had been some issues in Kirklees in relation to recruitment of NHS staff as AMHPs, particularly around pay grading and it had proved too complicated to take forward. TB agreed to follow this up with Craig Limbert to understand the issues raised and whether there is any further action the Trust can take, with an update to the next meeting.

Action: Tim Breedon

MHAC/13/19 Any other business

Consultant representation

NHB asked if the Committee would find it useful for an additional consultant to attend Committee meetings. HW responded that she would rather there was one regular consultant (currently Dr Lakidis) and another who came to meet the Committee and present on an area of practice.

The Act in practice

The presentation to the next meeting will be on capacity and consent in relation to both informal and formal patients, including appropriate use of the Mental Capacity Act and Deprivation of Liberty.

Action: Yvonne French

Hospital managers' payment and expenses

As previously agreed, Hospital Managers' payment and expenses are reviewed every April. The Committee was informed that there would be an uplift of 1%, which is consistent with that awarded to NHS staff, and no change to travel expenses, which reflects Trust arrangements.

MHAC/13/20 Date of next meeting

The next meeting will be held on Tuesday 6 August 2013 from 14:00 to 16:30 in the Manor room, 5th floor, F Mill, Dean Clough, Halifax.

Minutes of the Remuneration and Terms of Service Committee held on 23 April 2013

Present:	Ian Black	Chair of the Trust (Chair)
	Helen Wollaston	Deputy Chair of the Trust
	Steven Michael	Chief Executive
Apologies:	Jonathan Jones	Non-Executive Director
In attendance:	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/13/21 Welcome, introduction and apologies (agenda item 1)
The Chair (IB) welcomed everyone to the meeting. The apology, as above, was noted.

RTSC/13/22 Minutes of the previous meeting held on 12 February 2013 (agenda item 2)
It was RESOLVED to APPROVE the minutes from the meeting held on 12 February 2013.

RTSC/13/23 Matters arising from previous meeting (agenda item 3)
There were two matters arising.

RTSC/13/11 Clinical Excellence Awards
There is still no outcome from the national consultation on the Awards for 2012/13. The Trust will wait for guidance to ensure its arrangements are in line with those nationally.

RTSC/13/15 Management of medical workforce
Alan Davis (AGD) with work with the Medical Director to bring a paper back to the Committee in July 2013.

Action: Alan Davis

RTSC/13/24 HR exception report (agenda item 4)
Sickness absence
End-of-year sickness absence figures were tabled. The trend has been upwards during 2012/13 and forensic services remain a concern and an outlier.

In 2013/14, performance management in relation to sickness absence needs to be more robust and visible. Achieving the 4.25% target will be a huge challenge and must be part of objectives across the organisation with strong operational performance management at senior level.

Appraisal
The Trust achieved 84.7% for the twelve months ending 31 March 2013. The next target is to achieve 80% by the end of the first quarter of 2013/14 although it is

appreciated that introduction of the new values-based system may affect this adversely.

Turnover
IB will raise turnover in Wakefield BDU with Sean Rayner.

Action: Ian Black

RTSC/13/25 Approval of redundancy business case (agenda item 5)
It was RESOLVED to APPROVE the proposed redundancies, subject to suitable alternative employment not being available before the date of termination.

RTSC/13/26 Management structures (agenda item 6)
The Committee noted the update from the Chief Executive.

RTSC/13/27 Any other business (agenda item 7)
Trust Board appraisals
Executive Director appraisals are led by the Chief Executive who takes soundings from others, particularly Non-Executive Directors, and this will be completed by 10 May 2013. Recommendations on performance related pay and a summary of the appraisal outcomes will be presented to the Committee on 21 May 2013.

Action: Steven Michael

The Chair leads the Non-Executive Director appraisal process and takes soundings from Executive Directors, particularly lead Directors on Committees. Non-Executive Director appraisals will be completed by the end of June 2013 to follow and reflect the arrangement for Executive Directors and staff.

Action: Chair

Date of next meeting
As discussed at the meeting on 16 April 2013, IB is keen that the Committee meets before the end of May 2013 to look at the recommendations from SM on performance related pay in order for Jonathan Jones (JJ) to be involved. It was agreed that this meeting should take place on 21 May 2013. This also supports IB's wish for the annual accounts for 2012/13 to include the exact numbers for variable pay. Therefore, any approval by the Committee needs to be before the Audit Committee meets on 23 May 2013.

In future years, IB would like to see an additional meeting scheduled to review performance related pay recommendations, accounts disclosures and the remuneration report contained in the annual report and accounts. The Trust will be favouring openness in its disclosure on directors' pay beyond the statutory minimum.

Action: Chair

The meeting on 21 May 2013 will also consider any further redundancies that may arise and the remuneration report from the annual report and accounts for 2012/13. IB commented that he would like the Trust to be open and transparent on statutory

pay disclosures in the accounts, such as individuals earning over £100,000 and Directors' performance related pay.

Action: Alan Davis

Payment to governors

IB was of the view that the Trust should wait for the outcome of any national lobbying by the Foundation Trust Governors' Association and others before considering this further. Any change would require a change to the current legislation. The Committee was very much of the view that payment to governors would lead to confusion about the role and loss of clarity of purpose.

Staff survey

A summary of the outcome and action plan arising from the staff survey will be included in the HR report to Trust Board on 30 April 2013. The outcome of the wellbeing survey will be reported to the Committee.

Action: Alan Davis

RTSC/13/28 Date of next meeting (agenda item 8)

The next meeting will be held on Tuesday 21 May 2013 (time to be confirmed). This will be followed by the scheduled meeting on Tuesday 16 July 2013 at 14:00 in the Chair's office at Fieldhead, Wakefield.

Trust Board 25 June 2013
Agenda item 6

Title:	**Annual report, accounts and Quality Report 2012/13**
Paper prepared by:	Directors of Finance, Corporate Development and Nursing, Clinical Governance and Safety
Purpose:	To enable Trust Board to receive and adopt the annual report, accounts and Quality Report for 2012/13.
Vision/goals:	The annual report, accounts and Quality Report form part of the Trust's governance arrangements, which support the Trust's vision and goals. The annual report provides a summary of the Trust's performance, the accounts demonstrate financial probity and the Quality Report outlines the Trust's approach to quality and achievement of its quality priorities.
Any background papers/ previously considered by:	The full annual report, accounts and Quality Report for 2012/13 are available on request for members of Trust Board. This suite of documents will be available to the public once they have been laid before Parliament at the end of June 2013.
Executive summary:	Background The Audit Committee has delegated authority from Trust Board to review, scrutinise and approve the annual report, accounts and Quality Report. The Committee reviewed and approved the documents for 2012/13 at its meeting on 23 May 20132. The report and accounts with supporting documents were submitted to Monitor in line with the national timetable and have been submitted to the Department of Health for laying before Parliament. Annual report 2012/13 The annual report was developed in line with Monitor's requirements and this was confirmed by the Trust's external auditors. The Committee approved the report. Annual accounts 2012/13 The Audit Committee considered the report from the Director of Finance on the final accounts (attached for Trust Board), the Head of Internal Audit Opinion (see below) and the findings of the external auditors, Deloitte (ISA 260 attached for Trust Board). The Trust met all its financial targets and achieved a Monitor rating of 4.3. The Trust received an unqualified audit opinion on the 2012/13 accounts and a positive opinion on the requirement to demonstrate Value for Money. Deloitte also confirmed that the remaining areas outlined on page 4 of its report had been completed. The Head of Internal Audit Opinion for 2012/13 provided significant assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. There was one mis-statement in the accounts, which was corrected, and there was no overall impact on the accounts as a result of this mis-statement. Two recommendations were made in relation to risk management and internal controls systems.

	1. A formal, legally-binding lease agreement should be established for the Dales with Calderdale and Huddersfield NHS Foundation Trust (CHFT). The Trust has confirmed with CHFT that this will be a priority in 2013/14. 2. The Trust should develop a formal project plan for the implementation of Payment by Results. The Trust has confirmed that a project plan will be developed during 2013/14. The Committee approved the accounts for 2012/13. <u>Quality Report</u> As requested by Trust Board, the Quality Report was scrutinised in detail by the Clinical Governance and Clinical Safety Committee prior to its presentation to the Audit Committee and a recommendation made for it to be formally approved. The Quality Report will be published on the NHS Choices website at the end of 30 June 2013 once laid before Parliament. The external assurance review conducted by Deloitte was received by the Audit Committee on 23 May 2013 (included in these papers for Trust Board). The audit reviewed the content against Monitor's Annual Reporting Manual and for consistency with other reporting mechanisms. Both were found to be satisfactory and Deloitte issued the required limited assurance opinion. The report noted a significant improvement on the 2011/12 Report and provided one recommendation in relation to more detailed explanation of data tables. Deloitte also undertook a data quality review of two nationally mandated indicators (delayed transfers of care and access to crisis resolution teams). The required limited assurance opinion was issued. Deloitte also audited a further indicator in relation to incidents resulting in severe harm or death, which was not part of the limited assurance opinion. Six recommendations were made and an action plan against the auditor's recommendations has been agreed. This will be monitored by the Clinical Governance and Clinical Safety Committee as part of its scrutiny of the Quality Report process and content. The Committee approved the Quality Report for 2012/13. <u>Members' Council</u> The annual report, accounts and Quality Report and associated auditors' reports will be presented to the Members Council at the end of July 2013.
Recommendation:	**Trust Board is asked to receive and adopt the annual report, accounts and Quality Report for 2012/13.**
Private session:	Not applicable.

Trust Board
25 June 2013

Annual Accounts Financial Year 2012/13

1.0 Introduction

On behalf of Trust Board, the Audit Committee scrutinised the Trust's annual accounts for the financial year ended 31 March 2013, and to subsequently decide whether to recommend the Trust Board adopt these accounts. The Trust is required to submit its financial position for the period 1 April 2012 to 31 March 2013 to Monitor in the required format.

The following report provides an analysis of the balances within the accounts and links them back to the overall Trust position reported in year to Trust Board.

The accounts are made available to the public as part of the Trust's Annual Report. This report includes details of the Trust's Quality Report. The content of the Annual Report has been reviewed by Deloitte to ensure it meets disclosure requirements and the quality report has been subject to a formal audit. In addition, the Members' Council has a standing sub-group, which has been actively involved in the compilation of the Quality Report for 2012/13.

2.0 Trust Financial Performance 2012/13 overall

The Trust's planned annual surplus for 2012/13 was £5.9 million; actual surplus was £6.0 million and overall was £120,000 better than planned. Capital expenditure for the year was £9.2 million against an original plan of £10.4 million; the main elements of the underspend relate to deferred schemes on the Fieldhead and Sycamores sites, the RiOIT project and funding earmarked for the Estates Strategy. These will be required in 2013/14.

Monitor's financial risk rating at the end of March was 4.3. This was better than the plan of 3.6 for the year, due to better than planned EBITDA and surplus performance.

The Trust's cash position remained strong throughout the year with sufficient resources to meet its outgoings and any surplus balances were invested in line with the Treasury Management Policy to maximise interest receivable.

Although not a requirement for Monitor, the Trust Board supports the NHS better payment practice code which sets a target of paying 95% of valid invoices within 30 days of receipt. The Trust paid 96% of invoices within 30 days. In addition the Government has requested all public sector bodies to pay small and medium sized suppliers within ten workings days given the challenging economic climate. In response to this the Trust paid 83% of local suppliers within ten days during 2012/13 to help sustain local communities.

The Trust recurrently achieved its cost improvement programmes during 2012/13. Of identified recurrent schemes, £79,000 was delayed but was met by non-recurrent substitutions in-year and has been implemented for 2013/14.

3.0 Background

Foundation Trusts have to produce annual reports, quality accounts and audited accounts to clearly defined timescales set by Monitor as the regulatory body. The format of the accounts is specified by the Secretary of State and broadly adheres to International Financial Reporting Standards commonly referred to as IFRS.

The accounts are included in full in the Annual Report as required by Monitor. These are subject to review by Deloitte as the Trust's External Auditors; who have to give a formal opinion on the accounts.

Deloitte presented its ISA260 Report (Communication of Audit Matters to Those Charged with Governance) to the Audit Committee. The report records any adjustments and audit amendments agreed in finalising the accounts and highlights any issues that have arisen during the audit.

3.1 Annual Accounts

This is the format of accounts made available to the public and presented at the annual members' meeting. They are commercial in style and include notes on accounting policies. The accounts presented to and approved by the Audit Committee were the final version and included agreed audit adjustments.

3.2 Summarisation Schedules (FTCs)

These form the internal Foundation Trust accounts and are consolidated to produce overall accounts for the NHS. They show the in-year and prior year balances and provide additional information for reconciling intra-NHS debtors, creditors, income and expenditure. The figures in these spreadsheets are linked and cross checked to the accounts presented in narrative form.

3.3 Submission Deadlines and Adjustments

For 2012/13 the draft accounts were required to be submitted to Monitor and made available to Audit by 9:00 on 22 April 2013. The accounts were submitted on time. The audited accounts were sent to Monitor by the required date (30 May 2013) both electronically and in hard copy.

The audit commenced on 22 April 2013. Since submission in April the accounts have been amended for one classification adjustment relating to fixed assets as detailed in the ISA 260 report.

3.4 The Annual Governance Statement

The Chief Executive, as Accounting Officer, has a responsibility to consider the adequacy and effectiveness of the Trust's system of internal control. The outcome of this review is reported in a statement in the Annual Report as required.

The Trust is required to disclose any significant matters in the Annual Governance Statement. For this accounting period the major strategic risks arose from the current economic climate and the challenges that brings, changes within the Commissioning environment and Any Qualified Provider (AQP), the potential impact of Payment by Results on Mental Health, data quality and capture of clinical information on RiO (the Trust's clinical information system), including the rollout and development of RiO across the whole Trust, and the risk associated with the transfer of PCT estate to the Trust.

3.5 Accounting Policies

For 2012/13 the Trust updated its accounting policies in line with changes in accounting standards and associated guidance. Changes to these policies were discussed and approved by Audit Committee in February before adoption. There was no requirement for any prior period adjustments.

3.6 Major Judgement Areas

Trust Board has approved a challenging cost saving programme for 2013/14 and beyond. As a result, a number of posts are at risk and will result in a number of redundancies. This affects approximately 70 whole time equivalent posts during 2013/14 and further redundancies during 2014/15. The Trust has estimated the associated redundancy costs and made provision for them in the 2012/13 accounts.

4.0 Analysis of the Annual Accounts

4.1 Statement of Comprehensive Income (Income & Expenditure Account)

4.1.1 Income

Total income for the year was £232.4 million (£231.1 million for 2011/12). This is split into income from healthcare activities and other operating income.

For 2012/13 the income from healthcare activities remained relatively static, reducing by £61,000.

Other operating income was £13.1 million in 2012/13 (£11.7 million in 2011/12). This increased income arises from increased participation in the Trust lease car scheme and therefore higher contributions. This also includes additional funding for hosted budgets such as Altogether Better and specific projects.

4.1.2 Expenditure

Total operating expenditure increased by £1.5 million (0.7%) to £225.0 million (£223.5 million in 2011/12). The main changes relate to:

- staffing costs and number of staff employed;
- staff costs reducing by £1 million (0.6%);
- supported by the reduction of 32 WTE compared to 2011/12 which is an increase of permanently employed staff (by 38) and a reduction in other staff including agency (by 70);
- overall agency expenditure has reduced by £1.3 million;
- non-pay costs have increased by £2.5 million.

4.1.3 Operating Surplus

The Trust's 2012/13 operating surplus before dividends and interest is £7.5 million. The surplus in 2011/12 was £7.6 million and is therefore a reduction of £0.1 million. This movement is an offset of the in-year impact of tariff deflation by a similar reduction in operating expenses.

4.1.4 Interest

Interest received on bank deposits during the year was £374,000 (£273,000 2011/12). No interest payments were made during the year.

Interest received was also higher than planned (£124,000) and, as a consequence, has facilitated the Trust position of achieving a surplus above planned.

The Trust plan for 2013/14 includes an assumption that interest income will reduce from the level received in 2012/13. This is due to reductions in market rates and also the investment options available to the Trust due to changes within the PDC calculation.

4.1.5 Public Dividend Capital (PDC)

Public dividend capital dividend payable during the year amounted to £1.6 million (£1.5 million 2011/12).

4.1.6 Retained Surplus

The Trust's retained surplus after interest, taxation, depreciation and amortisation for 2012/13 was £6 million (£6.3 million 2011/12). No financial support was provided to the Trust during the year and the Trust received no loans.

4.2 Statement of Financial Position (Balance Sheet)

4.2.1 Non Current Assets (Fixed Assets)

Non-current assets have increased by £5 million from 2011/12 (7.3%). This totals £69.1 million.

Intangible Assets

Intangible assets have increased in year by £303,000 due to purchase of a software licence.

Property, Plant and Equipment – PPE (formerly Tangible Fixed Assets)

In summary, the changes reflect an increase for the capital expenditure less any depreciation during the reporting period, and include the impact of any asset revaluation.

- A total of £8.2 million was included as additions to capital assets during 2012/13. The major scheme for the year was the building of additional accommodation at Newton lodge to enhance and increase the provision of service. This is due to be completed in 2013/14. The balance was spent on a number of minor capital schemes to improve the quality of our estate, meet regulatory requirements and sustainability projects to reduce the Trust's environmental impact.
- Total depreciation for the year was £2.9 million.

Investment Property

Following the sale and revaluation of Trust Investment Property the value has reduced to £0.4 million (£0.8 million in 2011/12).

4.2.2 Stock

Over the 12 month period there has been a £29,000 increase in stock. There has been no change in counting or accounting policy around stock.

4.2.3 Trade and Other Receivables (Debtors)

Receivables have decreased by £0.6 million. The increase is primarily as a result of a reduction in NHS debtors as invoices were raised as early as possible so that actual

payment could be made before year end.

There has been no material change in the length of time debts are outstanding and NHS debtors over 60 days were £94,000 as at 31 March 2013. Action plans are being developed to resolve these.

4.2.4 Cash

Cash at bank and in hand was £29.9 million as at 31 March 2013 (£27 million at 31 March 2012).

4.2.5 Trade and OtherPayables (Creditors)

Trade and otherpayables have reduced by £1.5 million overall on last year. The decrease is primarily as a result of a reduction in NHS creditors due to faster payment in order to meet the better payment practice code and continued work to ensure that any issues are resolved in a timely fashion.

4.2.6 Provisions (Current and Non-Current)

There has been an overall increase of £2.5 million in provisions over the period. This mostly relates to an additional provision for redundancy costs. The total provision at 31 March 2013 is £8.1 million (£5.5 million at 31 March 2012). The remaining provisions relate to pensions and other legal claims liabilities.

4.2.7 Other liabilities (Current and Non-Current)

These relate to deferred income which has increased to £0.8 million in 2012/13 (£0.4 million in 2011/12). This relates to hosted budgets (Altogether Better) funding which moved to the Trust in 2012/13 and was therefore not included in the 2011/12 figures. This is project funding from the Big Lottery to support the workstreams continuing for Altogether Better.

There are no prior period adjustments.

4.2.8 Statement of Changes in Taxpayers Equity (Capital and Reserves)

The movements for the year relate to the retained surplus for the accounting period and movements between the revaluation reserve and the income and expenditure reserve as a result of adjusting the revaluation reserve balances for assets.

4.3 Statement of Cash Flow – Page 5

The Trust has £29.9 million of cash as at 31 March 2013 (£27.0 million at 31 March 2012). This is an increase of £2.9 million (9.7%).

The net cash generated from operating activities for the period was £12.4 million. The breakdown of this is £7.5 million from the surplus; £2.9 million from depreciation; £0.6 million from the increase in receivables; £0.4 million from the increase in other liabilities and £2.5 million increase in provisions. These increases were partially offset by an £1.5 million decrease in payables.

The interest received in the period was £0.4 million.

Cash outflows included capital expenditure £8.3 million and £1.6million for dividend payments.

4.4 Remuneration Report

The Trust is required by its Regulators to make available to the public details of senior managers' remuneration. Full remuneration and pension reports have been included in the Annual Report and in the accounts.

Directors Performance Related Pay has been awarded for 2012/13 and is reflected in the pay expenditure of the Trust. However, as payment will be made in 2013/14, this is not included within the remuneration table and will be reflected within the 2013/14 disclosure.

The Remuneration ratio has increased from 6.1 to 7.0; however this is due to the retirement of a director with significant exit costs and does not reflect an underlying trend.

Deloitte.

South West Yorkshire Partnership NHS Foundation Trust

Report on the financial statement audit for the year ended 31 March 2013

May 2013

Deloitte.

Dear Sirs

We have pleasure in setting out in this document our report to the Audit Committee of South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2013, for discussion at the meeting scheduled for 23 May 2013. This report covers the principal matters that have arisen from our audit for the year ended 31 March 2013.

In summary:

- Our audit testing is largely complete; work is continuing on some aspects of the underlying financial statement audit work and non-financial statement items specified in the Executive Summary.
- The significant risks, which are summarised in the Executive Summary, have now been largely addressed and our conclusions are set out in our report.
- We will present our opinion, findings and recommendations at the Audit Committee meeting on 23 May 2013.
- In the absence of unforeseen difficulties, management and ourselves expect to meet the agreed audit and financial reporting timetable.

We would like to take this opportunity to thank the finance team for their assistance and co-operation during the course of our audit work.

Paul Thomson

Senior Statutory Auditor

Contents

Executive summary

Status	Description	Detail
Completion of the audit		
Audit in line with agreed timetable. Accounts to be signed by 31st May 2013	The status of the audit is as expected at this stage of the timetable agreed in our audit plan. The following are the remaining areas we are required to complete to finalise the financial statement audit: • Copy of financial statements with updates made. The following are the remaining areas we require in order to complete our remaining work: • Outstanding items on Annual Report testing; • Quality Accounts review; • Charitable Funds audit; • Whole of Government accounts audit work; and • Receipt of management representations.	
Overall view		
We anticipate issuing an unmodified financial statement audit opinion	On satisfactory completion of the outstanding matters, we anticipate issuing an unmodified audit opinion on the truth and fairness of the financial statements. The matters that we have taken into account in forming our overall view are described in the following sections.	
The findings from our work on the Quality Report are set out in a separate report	We will issue a public opinion on the 2013 Quality Report. We anticipate issuing an unqualified limited assurance opinion on the Quality Report and the two mandated indicators. We have prepared a separate report for the Audit Committee setting out the findings from our work on the Quality Report.	Separate report

Executive summary (continued)

Significant audit risks		Status	
Our testing on significant risks has not identified any material adjustments to the accounts	Our findings on significant audit risks are as follows: **Delivering Cost Improvement Plan** A risk has been raised regarding the delivery of CIP during a time of increased pressure on the Trust's resources. No issues have been noted. **Implementation of Payment by Results (PbR)** A risk has been raised in regards to the implementation of PbR which will result in increased pressure on data quality and information monitoring systems. It has been noted that whilst significant progress has been made in preparation for PbR, there is no formal project plan in place for implementation of PbR. A recommendation has been raised in section 4. **Acquisition of PCT Estate** A risk has been raised regarding the acquisition of PCT estate. The acquisition took place post year end in April 2013 and therefore the accounting treatment of the acquisition did not affect the current year accounts. No issues have been noted. **Revenue Recognition** Auditing standards require a presumed risk of revenue recognition. At the Trust, this risk is specific to late amendments to contracts. No issues have been noted. **Management Override of Controls** Auditing standards require us to raise a presumed risk regarding management override of controls. No issues have been noted from our testing of this risk. No issues have been noted.	● ● ● ● ●	Section 1

● Risk appropriately addressed ● Risk satisfactorily addressed but with unadjusted errors identified ● Material unresolved matter

Executive summary (continued)

Status	Description	Detail
Our observations on your financial statements		
We are currently waiting for the final version of the annual accounts to enable us to conclude following our comments given to management on the current draft	The following financial reporting presentational and disclosure matters are significant to the 2013 accounts: • Going concern; • Hutton disclosures on median pay; • Disclosure of critical accounting judgements and key sources of estimation uncertainty; • Related party disclosures; and • Non NHS income. Section 3 considers these matters in more detail.	Section 3
Risk management and internal control systems		
We have raised two insights over the internal control systems within the Trust. None of these impacted upon our audit approach	As set out in the Annual Governance Statement, management's assessment of the risk management and internal control systems concluded that the system is operating in a satisfactory manner. Our audit findings did not identify any significant deficiencies in the financial reporting systems. We have raised recommendations in the following areas: • Formal lease agreements; and • A formal PbR project plan. None of these items warranted a key audit risk.	Section 4

Executive summary (continued)

Status	Description	Detail
Identified misstatements and disclosure misstatements		
Corrected misstatements total **£127k. The overall impact on the accounts is nil. There are no uncorrected misstatements**	Audit materiality was £2.29m. Corrected misstatements identified to date total £127k. They relate to re-classification of balances and hence have no impact on the reported surplus, net assets and prior year retained earnings. The definitive summary of corrected misstatements will be attached to the representation letter obtained from the Board of Directors. Details of recorded audit adjustments are included in Appendix 1.	Appendix 1
Significant representations		
Management representations will be circulated separately	A copy of the representation letter to be signed on behalf of the Board has been circulated separately.	Circulated separately
Independence		
We have noted no issues relating to independence	Our reporting requirements in respect of independence matters, including fees, are covered on page 13.	Page 13
Liaison with internal audit		
We have reviewed internal audit reports published in the year. **No issues have been noted**	The audit team, following an assessment of the independence and competence of the internal audit department, reviewed internal audit reports and adjusted our audit approach as deemed appropriate.	N/A

1. Significant audit risks

The results of our audit work on significant audit risks are set out below:

Delivering the cost improvement plan		Deloitte response
Our testing concluded that there is sufficient clinical involvement in the CIP-setting process	As a consequence of the combined impact of rising demand, high public and commissioner expectations around quality and the squeeze on healthcare expenditure, the delivery of a challenging cost improvement plan will form an increasingly pivotal role in securing the Trust's financial health and delivering the medium term financial plan. There is the risk that the pressure to achieve CIPs could result in a negative impact on clinical quality at the Trust.	We have reviewed evidence of clinical involvement in the CIP-setting process and reviewed the monthly performance reports presented to the Board. We noted there appeared to be appropriate clinical and Board involvement in the setting of CIP targets and no issues were identified surrounding the integrity of the medium term plan or the going concern status of the Trust.

Implementation of payment by results		Deloitte response
The continuing programme to introduce PbR into the mental health sector will continue to be a challenge to the Trust and presents a risk connected to financial stability and operational arrangements	The switch from block contracts to a system through which the Trust is paid based upon activity and outcomes poses clear risks to the stability of the Trust's key revenue streams. The introduction of PbR will have significant implications for the financial and operational arrangements of the Trust and as such proper preparation is essential to ensure both financial stability and adequate control through the implementation stage.	An understanding of the Trust's position in PbR has been obtained at the interim audit stage and followed up at the final stage. Our audit approach involved a review of the PbR guidance to understand what was required of the Trust. It is recognised that the Trust has made significant progress on PbR and achieved key milestones both in 2012/13 and 2013/14; however, a formal project plan is yet to be developed. A recommendation with regard to this has been raised in section 4.

Acquisition of PCT estate		Deloitte response
The potential acquisition of estate from PCTs poses a specific risks around presentation within the financial statements as well as an operational risk connected to estate rationalisation following acquisition	The Trust anticipates acquiring a portfolio of estate from PCTs. The acquisition of the estate may trigger the need (or present an opportunity) for estates rationalisation. Where rationalisation is planned or occurs there may be a need to recognise costs associated with this e.g. in the form of dilapidation or onerous lease provisioning.	This acquisition took place post year end in April 2013 and therefore the accounting treatment of the acquisition did not affect the current year accounts. Deloitte have considered the estates strategy going forward which incorporates PCT estate.

1. Significant audit risks (continued)

Revenue recognition		Deloitte response
Our testing concluded that revenue recognition was in line with relevant accounting standards	Under auditing standards we are required to assume a risk of material misstatement of the financial statements as a result of management manipulation of revenue recognition. This risk has been identified at the Trust as being associated with late amendments to contracts. This could result in cut-off issues which could lead to the manipulation of the closing reported position at the end of the year. We also identified issues in the prior year in regards to late amendments to contracts not being formally agreed and documented.	We have reviewed invoices raised pre and post year end and ensured that revenue has been recorded within the correct period. We also analysed major contract variations with NHS bodies, with no issues noted in regards to revenue recognition. In the prior year audit, we raised a recommendation that formal documentation should be in place for all contract variations. In the sample of contract variations selected as part of our audit testing in the current year we did not note any issues regarding lack of formal documentation for contract variations.

Management override of controls		Deloitte response
No instances of management override of controls were noted as a result of our testing	Under auditing standards we are required to assume a risk of fraudulent misstatement of the financial statements as a result of management override of controls. This is with respect to the financial reporting process, accounting estimates and key judgements.	The rationale behind a sample of journal entries has been substantiated to supporting documentation. Accounting judgements and estimates have been reviewed for possible management bias. No issues have been noted from our testing.

2. Value for Money Conclusion

The Trust's Arrangements to Secure Value for Money	
Status - ● **No issues noted with respect to the use of resources.**	**Background** Monitor's Audit Code for NHS Foundation Trusts sets out a requirement that auditors must satisfy themselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Audit Code advises that, in discharging this responsibility, auditors should take account of: • the statement made by the Accounting Officer of the NHS Foundation Trust as part of the Annual Governance Statement; and • the results of work of relevant regulatory bodies, for example the Care Quality Commission and Monitor.
Deloitte response	We have obtained an understanding of the Trust's arrangements for securing "value for money", through a combination of: • review of the Trust's draft Annual Governance Statement; • consideration of issues identified through our other audit and assurance work; • consideration of the Trust's results, including the level of achieved surplus and CIP for 2012/13 and the forecasts and identified savings for 2013/14; • review of capital monitoring programmes, evidencing appropriate monitoring and project management; • review of Monitor's finance and governance risk ratings. The latest risk ratings published by Monitor are 4 and green respectively; and • review of correspondence with regulators, CQC. We have not identified any issues which we need to report in our audit opinion in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources.

3. Our observations on your financial statements

In the course of our audit of the financial statements, we consider the qualitative aspects of the financial reporting process, including items that have a significant impact on the relevance, reliability, comparability, understandability and materiality of the information provided by the financial statements. Our comments on the quality and acceptability of the Trust's accounting policies and estimates are discussed below.

Going concern	
Description	There is no presumption of going concern status for NHS Foundation Trusts. Directors must decide each year whether or not it is appropriate for the NHS Foundation Trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows. The NHS Foundation Trust should include a statement on whether or not the financial statements have been prepared on the going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary.
Deloitte response	We have reviewed the going concern assumption of the Trust and agreed with management's viewpoint that they can continue as a going concern for the next 12 months. The Trust anticipates a surplus of £3.7m in 2013/14. The plan for 2013/14 includes a CIP target of £7.7m, and detailed plans for achievement of this target have been shared and approved by the Board. The Trust has total cash of £29.9m at the year end. We have reviewed the going concern assumption of the Trust in line with the Annual Reporting Manual (ARM) and IFRS guidance and agree with management's viewpoint that the Trust can continue as a going concern for the next 12 months.

Hutton disclosures on median pay	
Description	For the 2012/13 financial year HM Treasury FReM requires disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid. The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Foundation Trusts are required to disclose information explaining the calculation, including the causes of significant variances where applicable.
Deloitte response	We have carried out tests of details on the Hutton disclosure and noted no numerical or presentation issues.

3. Our observations on your financial statements (continued)

Disclosure of critical accounting judgements and key sources of estimation uncertainty	
Description	IAS 1 requires disclosure of: • the critical judgements made in the process of applying accounting policies, which have the most significant effect on the amounts recognised in the financial statements; and • major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The Trust has identified the following as critical accounting judgements and key sources of uncertainty: • Pension provision; • Injury provision; • Valuation of PPE • Holiday pay accrual; and • Redundancy provision. During the year, we have held conversations with management in regards to the appropriate accounting treatment for the redundancy provision and the contract with St Luke's. We note that management have followed our recommendations and no misstatements or recommendations have been noted in these areas.
Deloitte response	With regards to the above critical judgement areas we have held discussions with management as to the methodology employed in the calculation of the provisions/accrual and the assumptions used. We have challenged management's assumptions and judgements through corroboration with supporting documentation and through discussions held with persons independent of finance and can conclude that the treatment in the financial statements is appropriate.

3. Our observations on your financial statements (continued)

Related party disclosures	
Description	The Annual Reporting Manual requires reporting of related party relationships, transactions and balances. The list of related parties for a Foundation Trust is defined as including key management personnel of the Department of Health ("DoH"), their close family members, and entities controlled or significantly influenced by these individuals.
Deloitte response	We have enquired of management whether there are any transactions that they are aware of with these parties. We have not identified any undisclosed related party transactions.

Non NHS income	
Description	One of the changes included within the Health and Social Care Act 2012 was to remove the private patient cap (and associated disclosures) and replace this with a non NHS income disclosure. A Trust is now judged to be compliant if less than 50% of its income derives from non NHS sources.
Deloitte response	The Non NHS Income disclosure shows that substantially less than 50% of income derives from non NHS sources. We have reviewed this disclosure and noted a small departure from established practice, which management have resolved. See Appendix 1.

4. Accounting and internal control systems

Internal control observations

In addition to the recommendations provided in relation to significant audit risks, we also identified a number of risk management and control observations, the most significant of which are detailed below.

Lease agreements	
Description	Our testing of the fixed assets balance found that there is no formal lease agreement for The Dales, a key property in delivering services for the Trust. The Trust sub-leases the property from CHFT, who cite the delay in forming a sub-lease with the Trust as a result of delays in updating and completing the head lease. The lack of formal lease agreement prevents the Trust from forecasting the length of the lease and the terms of the lease in the medium-to-long term future. It also raises uncertainty over the possibility of the Trust being able to use the building in the future and the potential impact of this on services delievered by the Trust.
Recommendation	A formal, legally-binding agreement should be established.
Management response	Management agree with the recommendation raised above. Dawn Gibson has been in contact with CHFT who state that the head lease was concluded and signed in September 2012. Both SWYPFT and CHFT are committed to agreeing the sub-lease and will treat this as a priority for 2013/14.
Timeframe	May 2013 onwards
Owner	Dawn Gibson

4. Accounting and internal control systems (continued)

PbR plan	
Description	PbR implementation is expected in the near future. The switch from block contracts to a system through which the Trust is paid based upon activity and outcomes poses clear risks to the stability of the Trust's key revenue streams. The introduction of PbR will have significant implications for the financial and operational arrangements of the Trust and as such proper preparation is essential to ensure both financial stability and adequate control through the implementation stage. It is recognised that the Trust has made significant progress on PbR and achieved key milestones both in 2012/13 and 2013/14, however a formal project plan is yet to be developed.
Recommendation	The Trust should develop a formal project plan for the implementation of PbR.
Management response	Management agree with the recommendation raised above. Actions will be taken to ensure that a formal plan is made. The lead director for implementation of PbR changed in February 2013 and the priority has been to consolidate the project arrangements both internally, and externally with commissioners, and also to achieve the key milestones for 2012/13 and contract baselines for 2013/14. A detailed implementation plan will be developed for 2013/14.
Timeframe	May 2013 onwards
Owner	Dawn Gibson

5. Independence

As part of our obligations under International Standards on Auditing (UK & Ireland) and the Companies Act, we are required to report to you on the matters listed below.

Confirmation	
We confirm our independence	We confirm that we comply with APB Revised Ethical Standards for Auditors and that, in our professional judgement, we are independent and our objectivity is not compromised.

Non-audit services	
We confirm that our independence is not compromised by our services provided to perform the review of the Quality Accounts, review of the charitable venture proposal and consultancy in respect of the Forensic Service	In our opinion there are no inconsistencies between APB Revised Ethical Standards for Auditors and the company's policy for the supply of non audit services or of any apparent breach of that policy. We apply the following safeguards to eliminate identified threats to independence or reduce them to an acceptable level:

Service provided	Identified threats to independence	Safeguards applied
Review of charitable venture	The potential threats to independence relate to self-review and involvement in management's decisions.	The review was not used as part of our audit of the financial statements. The report made recommendations to management only.
Consultancy in respect of forensic services	The potential threats to independence relate to self-review and involvement in management's decisions The review was carried out by a team separate to the audit team therefore no threats to independence.	A separate team undertook this work. This work was not directly relevant to the audit of the financial statements.

Fees	
The level of non audit fees is within appropriate guidelines	Details of the fees charged by Deloitte in the period from 1 April 2012 to 31 March 2013 are included in Appendix 2.

6. Responsibility statement

This report should be read in conjunction with the "Briefing on audit matters" included as an appendix to this report which sets out those audit matters of governance interest which came to our attention during the audit. Our audit was not designed to identify all matters that may be relevant to the board and this report is not necessarily a comprehensive statement of all deficiencies which may exist in internal control or of all improvements which may be made.

This report has been prepared for the Trust Board, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Deloitte LLP

Chartered Accountants

Leeds
May 2013

Appendix 1: Audit adjustments

Corrected misstatements

The following corrected misstatements have been identified up to the date of this report:

		Credit/ (charge) to current year income statement £'000	Increase/ (decrease) in net assets £'000	Increase/ (decrease) in prior year retained earnings £'000	Increase/ (decrease) in turnover £'000
Fixed Assets [1]					
Dr Intangible Assets			127.3		
Cr Plant and Machinery			(127.3)		
Total			0		

[1] Incorrect classification of a fixed asset. The cost of time spent by individuals developing and implementing the e-rostering system was classified incorrectly as plant and machinery.

Disclosure misstatements

Auditing standards require us to highlight significant disclosure misstatements to enable audit committees to evaluate the impact of those matters on the financial statements. Our preliminary review has identified the following disclosure deficiencies:

- Accuracy of the cash flow statement – corrected by management;
- Accuracy of non NHS income disclosure – corrected by management;
- Accuracy of the prudential borrowing limit note – corrected by management;
- Arithmetic accuracy of some notes due to rounding issues – corrected by management; and
- Completeness of economic lives of property, plant and equipment note – corrected by management.

Appendix 2: Independence – fees charged during the period

The professional fees earned by Deloitte (excluding VAT) in the period from 1 April 2012 to 31 March 2013 are as follows:

		2012/13 £'000
Fees payable to the auditors for the audit of the Trust's annual accounts		42.0
Charitable Funds audit		6.0
Quality Accounts		15.0
Non-audit services:		
Charitable venture proposal review	6.0	
Forensic services consultancy	63.7	
		69.7
Total auditors' remuneration		132.7

Appendix 3: Briefing on Audit Matters

Published for those charged with governance

This document is intended to assist those charged with governance to understand the major aspects of our audit approach, including explaining the key concepts behind the Deloitte Audit methodology including audit objectives and materiality.

Further, it describes the safeguards developed by Deloitte to counter threats to our independence and objectivity.

This document will only be reissued if significant changes to any of those matters highlighted above occur.

We will usually communicate our audit planning information and the findings from the audit separately. Where we issue separate reports these should be read in conjunction with this "Briefing on audit matters".

Approach and scope of the audit

Primary audit objectives

We conduct our audit in accordance with International Standards on Auditing (UK & Ireland) as adopted by the UK Auditing Practices Board ("APB"). Our statutory audit objectives are:

- to express an opinion in true and fair view terms to the members on the financial statements;
- to express an opinion as to whether the accounts have been properly prepared in accordance with the relevant Financial Reporting Manual;
- for certain disclosures relating to directors' remuneration to form an opinion as to whether they are made in accordance with the relevant Financial Reporting Manual; and
- to express an opinion as to whether the directors' report, including the business review, is consistent with the financial statements.

Other reporting objectives

Our reporting objectives are to:

- present significant reporting findings to those charged with governance. This will highlight key judgements, important accounting policies and estimates and the application of new reporting requirements, as well as significant control observations; and
- provide timely and constructive letters of recommendation to management. This will include key business process improvements and significant controls weaknesses identified during our audit.

Materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

Appendix 3 – Briefing on Audit Matters (continued)

Materiality (cont'd)

"Materiality" is defined in the International Accounting Standards Board's "Framework for the Preparation and Presentation of Financial Statements" in the following terms:

"Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size of the item or error judged in the particular circumstances of its omission or misstatement. Thus, materiality provides a threshold or cut-off point rather than being a primary qualitative characteristic which information must have if it is to be useful."

We determine materiality based on professional judgment in the context of our knowledge of the audited entity, including consideration of factors such as shareholder expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality to:

- determine the nature, timing and extent of audit procedures; and
- evaluate the effect of misstatements.

The extent of our procedures is not based on materiality alone but also the quality of systems and controls in preventing material misstatement in the financial statements, and the level at which known and likely misstatements are tolerated by you in the preparation of the financial statements.

Uncorrected misstatements

In accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK and Ireland)") we will communicate to you all uncorrected misstatements (including disclosure deficiencies) identified during our audit, other than those which we believe are clearly trivial.

ISAs (UK and Ireland) do not place numeric limits on the meaning of 'clearly trivial'. The Audit Engagement Partner, management and those charged with governance will agree an appropriate limit for 'clearly trivial'. In our report we will report all individual identified uncorrected misstatements in excess of this limit and other identified errors in aggregate.

We will consider identified misstatements in qualitative as well as quantitative terms.

Audit methodology

Our audit methodology takes into account the changing requirements of auditing standards and adopts a risk based approach. We utilise technology in an efficient way to provide maximum value to members and create value for management and the Board whilst minimising a "box ticking" approach.

Our audit methodology is designed to give directors and members the confidence that they deserve.

For controls considered to be 'relevant to the audit' we evaluate the design of the controls and determine whether they have been implemented ("D & I"). The controls that are determined to be relevant to the audit will include those:

- where we plan to obtain assurance through the testing of operating effectiveness;
- relating to identified risks (including the risk of fraud in revenue recognition, unless rebutted and the risk of management override of controls);
- where we consider we are unable to obtain sufficient audit assurance through substantive procedures alone; and
- to enable us to identify and assess the risks of material misstatement of the financial statements and design and perform further audit procedures

Appendix 3 – Briefing on Audit Matters (continued)

Other requirements of International Standards on Auditing (UK and Ireland)

ISAs (UK and Ireland) require we communicate the following additional matters:

ISA (UK & Ireland)	Matter
ISQC 1	Quality control for firms that perform audits and review of financial statements, and other assurance and related services engagements
240	The auditor's responsibilities to consider fraud in an audit of financial statements
250	Consideration of laws and regulations in an audit of financial statements
265	Communicating deficiencies in internal control to those charged with governance and management
450	Evaluation of misstatements identified during the audit
505	External confirmations
510	Initial audit engagements – opening balances
550	Related parties
560	Subsequent events
570	Going concern
600	Special considerations – audits of group financial statements (including the work of component auditors)
705	Modifications to the opinion in the independent auditor's report
706	Emphasis of matter paragraphs and other matter paragraphs in the independent auditor's report
710	Comparative information – corresponding figures and comparative financial statements
720	Section A: The auditor's responsibilities related to other information in documents containing audited financial statements

Appendix 3 – Briefing on Audit Matters (continued)

Independence policies and procedures

Important safeguards and procedures have been developed by Deloitte to counter threats or perceived threats to our objectivity, which include the items set out below.

Safeguards and procedures

- Every opinion (not just statutory audit opinions) issued by Deloitte is subject to technical review by a member of our independent Professional Standards Review unit.
- Where appropriate, review and challenge takes place of key decisions by the Second Partner and by the Independent Review Partner, which goes beyond ISAs (UK and Ireland), and ensures the objectivity of our judgement is maintained.
- We report annually to those charged with governance our assessment of objectivity and independence. This report includes a summary of non-audit services provided together with fees receivable.
- There is formal consideration and review of the appropriateness of continuing the audit engagement before accepting reappointment.
- Periodic rotation takes place of the audit engagement partner, the independent review partner and key partners involved in the audit in accordance with our policies and professional and regulatory requirements.
- In accordance with the Revised Ethical Standards issued by the APB, there is an assessment of the level of threat to objectivity and potential safeguards to combat these threats prior to acceptance of any non-audit engagement. This would include particular focus on threats arising from self-interest, self-review, management, advocacy, over-familiarity and intimidation.

Safeguards and procedures (cont'd)

- In the UK, statutory oversight and regulation of auditors is carried out by the Financial Reporting Council (FRC). The Firm's policies and procedures are subject to external monitoring by both the Audit Quality Review Team (AQRT, formerly known as the Audit Inspection Unit), which is part of the FRC's Conduct Division, and the ICAEW's Quality Assurance Department (QAD). The AQRT is charged with monitoring the quality of audits of economically significant entities and the QAD with monitoring statutory compliance of audits for all other entities. Both report to the ICAEW's Audit Registration Committee.

Independence policies

Our detailed ethical policies' standards and independence policies are issued to all partners and employees who are required to confirm their compliance annually. We are also required to comply with the policies of other relevant professional and regulatory bodies.

Amongst other things, these policies:

- state that no Deloitte partner (or any closely-related person) is allowed to hold a financial interest in any of our UK audited entities;
- require that professional staff may not work on assignments if they (or any closely-related person) have a financial interest in the audited entity or a party to the transaction or if they have a beneficial interest in a trust holding a financial position in the audited entity;
- state that no person in a position to influence the conduct and outcome of the audit (or any closely related persons) should enter into business relationships with UK audited entities or their affiliates;

Appendix 3 – Briefing on Audit Matters (continued)

- prohibit any professional employee from obtaining gifts from audited entities unless the value is clearly insignificant; and
- provide safeguards against potential conflicts of interest.

Remuneration and evaluation policies

Partners are evaluated on roles and responsibilities they take within the firm including their technical ability and their ability to manage risk.

APB Revised Ethical Standards

The Auditing Practices Board (APB) has issued five ethical standards for auditors that apply a 'threats' and 'safeguards' approach.

The five standards cover:

- maintaining integrity, objectivity and independence;
- financial, business, employment and personal relationships between auditors and their audited entities;
- long association of audit partners and other audit team members with audit engagements;
- audit fees, remuneration and evaluation of the audit team, litigation between auditors and their audited entities, and gifts and hospitality received from audited entities; and
- non-audit services provided to audited entities.

Our policies and procedures comply with these standards.

Independent Auditors' Assurance Report to the Council of Members of South West Yorkshire Partnership NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Members of South West Yorkshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of South West Yorkshire Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Members of South West Yorkshire Partnership NHS Foundation Trust as a body, to assist the Council of Members in reporting South West Yorkshire Partnership NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Members to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Members as a body and South West Yorkshire Partnership NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Delayed Transfers of Care; and
- Access to Crisis Resolution Teams;

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

Independent Auditors' Assurance Report to the Council of Members of South West Yorkshire Partnership NHS Foundation Trust on the Annual Quality Report (continued)

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the specified documents below:

- Board minutes for the period April 2012 to 29 May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to 29 May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from local Healthwatch organisations dated May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for the period April 2012 to March 2013.
- The 2012 national patient survey;
- The 2012 national staff survey;
- Care Quality Commission quality and risk profiles for the period April 2012 to March 2013.
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2012 to March 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.

- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

Independent Auditors' Assurance Report to the Council of Members of South West Yorkshire Partnership NHS Foundation Trust on the Annual Quality Report (continued)

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South West Yorkshire Partnership NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP

Deloitte LLP
Chartered Accountants
Leeds

29 May 2013

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview

Month 2 2013/14

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Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 2 2013/2014 (May 2013 information). 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

HIGH LEVEL PERFORMANCE SUMMARY (YEAR TO DATE)

OUTCOMES: **RAG Rating**

- **Monitor Governance risk rating**
- **Monitor Finance Risk Rating**
- **CQUINs**

CUSTOMER FOCUS

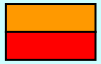
- **Complaints**
- **Members Council**
- **Annual Community Survey**

OPERATIONAL EFFECTIVENESS

- **Caseload management (7 day follow up; CPA review; gatekept admissions; DTOC)**
- **Data Quality**

FIT FOR THE FUTURE –WORKFORCE

- **Sickness**
- **Training**
- **Appraisals - data not available**



Trust Board Performance Dashboard – Vital Signs (Month 2 2013/14)

Business Strategic Performance: Impact & Delivery

Month 2 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Monitor Compliance	Monitor Governance Risk Rating (FT)	Green	Green	✓	–	4
	Monitor Finance Risk Rating (FT)	3.9	4.1	✓	–	4
CQC	CQC Quality Regulations (compliance breach)	Green	Green	✓	–	4
CQUIN	CQUIN Barnsley	Green	Amber/G	▲	–	3
	CQUIN Calderdale	Green	Amber/G	▲	–	3
	CQUIN Kirklees	Green	Amber/G	▲	–	3
	CQUIN Wakefield	Green	Amber/G	▲	–	3
	CQUIN Forensic	Green	Amber/G	▲	–	3
IAPT	IAPT Kirklees: % Who Moved to Recovery	52%	55%	✓	↑	4
Inf' Prevent'	Infection Prevention	0	0	✓	–	4
PSA Outcomes	% SU on CPA in Employment	10%	**7.2%**	✗	–	3
	% SU on CPA in Settled Accommodation	60%	**60.8%**	✓	↓	4

Customer Focus

Month 2 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	21%12/56	✓	↑	4
MAV	Physical Violence - Against Patient by Patient	19-25	Within ER	✓	↓	4
	Physical Violence - Against Staff by Patient	51 - 65	Within ER	✓	↑	4
FOI	% of Requests for Information Under the Act Processed in 20 Working Days	100%	100%	✓	–	4
Media	% of Positive Media Coverage Relating to the Trust and its Services	> 60%	85%	✓	–	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	> 50%	30%	▲	↓	3
	% of Quorate Council Meetings	100%	100%	✓	–	4
Membership	% of Population Served Recruited as Members of the Trust	1%	1.1%	✓	–	4
	% of 'Active' Members Engaged in Trust Initiatives	> 50%	40%	▲	–	3
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	> 70%	55.5%	▲	–	4
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	> 80%	87.5%	✓	↓	4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	> 90%	100%	✓	–	4

Operational Effectiveness; Process Effectiveness

Month 2 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**3.5%**	✓	↑	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**100.0%**	✓	↑	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	95.3%	✓	–	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**91.8%**	▲	↑	4
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	28.2%	✗	↑	3
Data Quality	Data completeness: community services (Monitor)	50%	83%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.5%**	✓	–	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**72.7%**	✓	↓	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	92.1%	▼	↓	3
	% of eligible cases assigned a cluster within previous 12 months	100%	75.2%	✗	↓	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	Data Not Available			4
C-Diff	C Diff avoidable cases	0	0	✓	–	4
Smoking	Number of 4 week smoking quitters (Barnsley only)	2408	2443	✓	↑	4

Fit for the Future; Workforce

Month 2 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Appraisal	% of Staff Who Have Had an Appraisal by End of June	>=90%	Data Available End of July			3
Sickness	Sickness Absence Rate (YTD)	<=4%	4.9	▼	↑	3
Vacancy	Vacancy Rate	10%	4.3%	✓	–	4
Safeguarding	Adult Safeguarding Training	80%	82.3%	✓	↑	4
Fire	Fire Attendance	>=80%	78.4	▲	↑	3
IG	IG Training	95%	8.03%	✗	↑	3

Integrated Performance Report: Strategic Overview

Overall Financial Position

	Performance Indicator	Month 2 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
Trust Targets					1						
1	£3.7m Surplus on Income & Expenditure	●	●	⇔	●						4
2	Cash position equal to or ahead of plan	●	●	⇔	●						4
3	Capital Expenditure within 5% of plan	●	●	⇔	●						4
4	In month delivery of recurrent CIPs	●	●	⇔	●						4
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●						4
6	In month Better Payment Practice Code	●	●	⇔	●						4

Summary Financial Performance

1. The overall position at month 2 is showing a net surplus of £1,321k which is ahead of plan. The planned surplus for the year is £3.7m and the current position is £354k ahead of plan.
2. At month 2 the cash position is £25.5m and is £1.0m behind plan.
3. Capital expenditure to May is £1.13m which is in line with plan.
4. At month 2 the cost improvement programmes are on track and forecast to achieve the planned level.
5. The Financial Risk Rating at May is 4.1 which is ahead of the planned Q1 3.9 position.
6. At 31st May 97% of NHS and 98% of non NHS invoices have achieved the 30 day payment target. (95%)

Integrated Performance Report: Strategic Overview

Financial Risk Rating 2013/14				
	May 2013 Actuals		Annual Plan Quarter 1	
Metric	Score	Rating	Score	Rating
EBITDA margin	7.7%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.0%	5	4.5%	5
I&E surplus margin	2.4%	4	1.9%	3
Liquid ratio	25	4	26	4
Weighted Average		4.1		3.9

The Monitor Financial Risk Rating (FRR) is 4.1 against a plan for Quarter 1 of 3.9.This is ahead of plan due to the underlying surplus position at May 2013.

- EBITDA margin scores 3 in line with plan.
- As a result EBITDA plan achieved scores 5 against a target of 5.
- Return on Assets remains on target at 5.
- Surplus margin scores 4 ahead of plan.
- Liquidity Ratio scores 4 against a plan of 4

Financial Risk Rating 2013/14				
	May 2013 Actuals		Annual Plan	
Metric	Score	Rating	Score	Rating
Liquidity	4 days	4	1 day	4
Capital Servicing	5 times	4	5 times	4
Weighted Average		4		4

The Monitor Risk Assessment Framework has proposed that the current 5 risk ratings are replaced by the 2 above. These will be shadow monitored at the beginning of 2013 / 2014. These are designed to demonstrate that a Trust remains a 'Going Concern.

Flawless Execution

PERFORMANCE OVERVIEW

1.0 OUTCOMES: IMPACT AND DELIVERY

1.1 Monitor Compliance Framework

- The Monitor Compliance risk rating for month 2 is Amber/Green due to underperformance on the % of service users on CPA who have had a formal review recorded within the last 12 months (91.8% as at month 2; target = 95%).
- None of the BDUs has achieved target levels in month 2
- 520 clients need to have a review recorded and a further 96 reviews need to be clinically validated by the end of June to achieve a green risk rating for the Quarter 1 submission (subject to all other criteria met).

1.2 CQUINs

1.2.1 Barnsley

- Overall Performance Rating: Amber/Green
- Current position unknown against some of the new CQUINs for Month 2 as systems and reporting continue to be established at a time when the Barnsley BDU has also transferred across to the RIO system;
- Systematic monthly monitoring and reporting is also being embedded for all existing CQUIN schemes where appropriate and monthly meetings to be set up between CQUIN leads, business managers and Quality Academy representatives to agree and implement remedial action.
- Key risk areas relate to:
    - Increasing the number of people in secondary mental health in employment, target set within realistic comparator group but will be difficult to achieve in the economic climate. Case to be built for continued discussion and negotiation with commissioners and reviewed once latest benchmarking available;
    - Improving health outcomes for people in secondary mental health services (BMI, Physical Activity, Weight Management) – work ongoing with services to ensure information recorded and correctly input to RIO;
    - Pressure Ulcer target reduction as part of National Safety Thermometer CQUIN. Finalising trajectory with commissioner. Some risk of attaining target linked to reduction of pressure ulcer incidence within community services.
    - Clinical Communication Outpatients – some risk associated with delays in sending out outpatient correspondence- with transfer to RIO look to address through generation of letters electronically. To facilitate through RIO optimisation.

Flawless Execution Continued

1.2.2 Calderdale, Kirklees & Wakefield

- Overall Performance Rating: Amber/Green
- Systems and reporting processes are now established across the majority of the CQUIN schemes
  - Some risks forecast in Q1 have not materialised: Risk on Health and Wellbeing CQUIN targets related smoking and physical activity have not materialised and schemes on track to achieve in Q1.
  - Interim results for the community and inpatient surveys also indicate more positive position than forecast in Month 1 currently on track to achieve 100% of the funding available for this CQUIN in Q1.
- Key risk areas relate to:
  - Mental Health Access Routine – assessment within 14 days – current performance remains at red across all BDUs. Action is ongoing to review the cases under target to identify data quality, reporting or clinical practice issues. Detailed review taking place with all BDUs.
  - Improving access to Psychological Therapy services – treatment within 16 weeks of assessment Wakefield BDU current performance red. Further review has shown potential valid cases to form legitimate exception reports and position being re-evaluated.
  - LD CQUINs – assurances currently being sought from service in relation to timeliness of collection of required datasets

1.2.3 Forensic

- Overall Performance Rating: Amber/Green
- Forecast position for Reducing Social Exclusion CQUIN improved from Amber/Green to Green
- Data collection template and guidance received 17th June from Commissioner for the Optimising Pathways CQUIN – to be used in the Quarter 1 submission in July. Clarifies requirements for Quarter 1 submission but some queries remain. Data collection from Quarter 2 onwards remains extremely challenging.
- Key risk areas relate to:
  - Optimising pathways – relates to optimising length of stay across the total care pathway.
  - Improving physical healthcare and wellbeing of patients – includes the monitoring of 8 specified aspects of physical health care/health promotion with the expectation that coverage will increase from 70% of patients in Q1 to 90 to 100% of patients will have this in place by Q4.
  - Improving service user experience through increased utilisation of communications technology

2.0 OPERATIONAL EFFECTIVENESS

2.1 Breastfeeding Prevalence 6 – 8 weeks

- There has been a slight increase in % children breastfed at 6 – 8 weeks but performance remains below target levels (28.2% against a target of 31.5%). Internal analysis of activity across the whole pathway was discussed with the CCG on 06/06/2013. The CCG has acknowledged the difficulties in meeting the SWYPFT target due to

Flawless Execution Continued

numbers transferring from the Midwifery Service. To be discussed with Commissioners at the next Quality/Performance meeting.

2.2 Mental Health Currency Development

2.2.1 External

- Ongoing workshops with commissioners
- Good SWYPFT representation (BDU and mental health currency development leads) at the CPPP *Commissioning Mental Health Services the Changing Landscape Workshop* on the 22nd May.
- Care Pathways and Package Project (CPPP)
  - SWYPFT hosts (and is well represented on) the National Quality and Outcomes Group
- IAPT (1 of the 9 areas currently excluded from PbR) are now looking for pilot sites
- (Year of Care) Long Term Conditions has now been taken up by Greater Huddersfield CCG : Data submitted for Year 1; awaiting commencement for Year 2

2.2.2 Internal

- Presentations delivered to Kirklees and Calderdale BDUs – presentations to the other BDUs to follow.
- Care pathways
  - Many directorates have been creating different pathways. This has now been brought together to identify standardised pathways that are integrated clinical processes and clinical record keeping. Further work to be developed re. timeframes and CQUINs
  - Pathways for referral and assessment in development
  -

2.2.3 Mental Health Clustering

- 92.1% eligible cases clustered as at Month 2 (97.6% in Month 1)
- 75.2% eligible cases clustered within the last 12 months (80.9% in Month 1)
  - The drop in % clustered is attributed to 2 factors: an increased focus on care transition protocols and the impact of the service transformation agenda within the teams.
  - The expectation is that performance will have improved by Month 3 following the work on the care transition protocols
- Further work being undertaken to ensure people have been accurately clustered and are being reviewed appropriately. Care Transition protocols and accurate recording of item scores remain the focus
- Targeted action against inappropriate allocation to clusters 0, 1, 2 and 3 continues especially with inpatients

Flawless Execution Continued

2.2.4 Care Coordination

- Practice Governance Coaches (Kirklees, Wakefield & Calderdale) leading work to ensure the recording of care coordinator for both standard care and CPA. This is also integrated into all Mental Health PbR frameworks/work plans

2.2.5 Quality and Outcomes

- PREM (patient reported experience measure)– Commencing 6 month Pilot from July, Team briefings being carried out.
- PROM (patient reported outcome measure)- work in progress - pilot to start in August
- CROM (Clinician rated outcome measure) – to be developed

2.2.6 Communication

- A communication plan is being developed which will include weekly updates and a quarterly newsletter
- Internal and external mental health currency/PbR packs to be reconfigured.

2.2.7 Diagnostic Coding

- Ongoing technical issues following the implementation of a module on the RiO System required to support robust coding going forward.
- Escalated to System Supplier – issues currently being investigated

2.3 Service Transformation

- Trust Transformation Programme progressing towards milestone of clear vision for each work stream in August 2013. Implementation Plans will follow thereafter
- Networks have been established for each work stream which covers mental health, general community, learning disability, and forensic services
- The central guiding coalition is Extended EMT, whose role is to challenge the work streams about both principles and progress and to hold work stream leads to account
- Work streams will link into the formal structures through the business and risk meetings of the Executive Management Team
- The Chief Executive will be meeting with work stream leads to evaluate progress and re-contract for future delivery
- A series of Transformation Programme engagement events will take place in June and July to begin shaping the process of co-production
- Detailed paper to go to July Trust Board

Flawless Execution Continued

3.0 FIT FOR THE FUTURE: WORKFORCE

3.1 Appraisal

- New appraisal system generally well received
- Some issues identified with conducting the number of 1:1 interviews required in areas where group appraisals have historically been conducted
- Roll out of new monitoring system to meet target of 90% by the end of June
- Data will be available July

3.2 Sickness

- Current absence rate for the whole of SWYPFT is 4.90% YTD (YTD = from January 2013). This is below the forecast projection (5.0%) and is an improvement on the month 1 position.
- With the exception of Calderdale, BDUs remain above the Trust target and are not forecast to achieve target levels by the end of 2013. Sickness rates in Support Services are also above target levels
- Of the 32 services lines within the Trust:
  - 17 are achieving absence rates below 4%.
  - 21 of the 32 areas have improved absence rates compared to those seen in January.
- Stress related absence continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4/5 days lost.
- Long term absence will continue to be a focus for reduction going forward. Approximately 70% of sickness absence is currently attributed to long term sickness. Reducing long term absence and the reduction of stress related absence remains a priority area for action.

3.3 Fire

- Fire training has seen a further increase from last month from 75.6% to 78.4% but remains below the Trust target. Communication drives to increase training figures has been done in areas such as Support Services. This is to improve their uptake in month 2 and 3, in an attempt to reach close to 100% uptake. This has been followed up with group training sessions in these areas in June which should further increase the overall uptake level above 80%. It is forecasted that Fire training will achieve 80% by the end of Q1 2013. BDU Workforce Plans for 2013-14 are making the improvement of uptake attendance a BDU priority objective and recently all BDUs were given detailed report breakdowns of where their staff are about to lapse so training can be planned.

3.4 IG Training

- The target is to achieve 95% staff trained by end of March 2014. Therefore we anticipate month on month improvement throughout the year. Consideration is being given to setting incrementally increasing quarterly targets.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report – Month 2 FY 2013/14

Commercial in Confidence

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Overall Financial Position

Finance Key Performance Indicators

	Performance Indicator	Month 2 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur -ance	Page
Trust Targets					1							
1	£3.7m Surplus on Income & Expenditure	●	●	⇔	●						4	4 to 5
2	Cash position equal to or ahead of plan	●	●	⇔	●						4	11
3	Capital Expenditure within 5% of plan	●	●	⇔	●						4	13 to 14
4	In month delivery of recurrent CIPs	●	●	⇔	●						4	6 to 7
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●						4	8
6	In month Better Payment Practice Code	●	●	⇔	●						4	16

Summary Financial Performance

1. The overall position at month 2 is showing a net surplus of £1,321k which is £354k ahead of plan.
2. At month 2 the cash position is £25.5m and is £1.0m behind plan.
3. Capital expenditure to May is £1.13m which is on target.
4. At month 2 the cost improvement programmes are on track and forecast to achieve to the planned level.
5. The Financial Risk Rating at May is 4.1 which is ahead of the planned 3.9 Quarter 1 position.
6. At 31st May 97% of NHS and 98% of non NHS invoices have achieved the 30 day payment target. (95%)

Overall Income & Expenditure Position

Budget Staff in Post WTE	Actual Staff in Post WTE	This Month Budget £m	This Month Actuals £m	This Month Variance £m	Income & Expenditure Account	Year to Date Budget £m	Year to Date Actual £m	Variance (Fav'ble)/ Adverse £m	Annual Budget £m	Forecast Outturn £m	Forecast Variance (Fav'ble)/ Adverse £m
					Healthcare Income						
		(3.04)	(3.04)	0.00	NHS Wakefield District	(6.12)	(6.12)	0.00	(36.70)	(36.70)	0.00
		(3.43)	(3.43)	0.00	NHS Kirklees	(6.86)	(6.86)	(0.00)	(41.16)	(41.16)	0.00
		(1.78)	(1.78)	0.00	NHS Calderdale	(3.55)	(3.55)	(0.00)	(21.32)	(21.32)	0.00
		(1.99)	(1.99)	(0.00)	Secure Services Commissioners	(3.98)	(3.98)	(0.00)	(23.86)	(23.86)	0.00
		(0.53)	(0.53)	0.00	Wakefield MDC	(1.07)	(1.07)	0.00	(6.40)	(6.40)	0.00
		(7.31)	(7.29)	0.02	NHS Barnsley	(14.62)	(14.57)	0.05	(87.64)	(87.44)	0.20
		(0.02)	(0.09)	(0.07)	Other Non Contract Healthcare Income	(0.05)	(0.13)	(0.08)	(0.30)	(0.40)	(0.10)
		0.00	0.00	0.00	Post Graduate Medical & Dental Income	0.00	0.00	0.00	0.00	0.00	0.00
		(18.10)	**(18.14)**	**(0.04)**	**Total HC Income**	**(36.24)**	**(36.28)**	**(0.03)**	**(217.38)**	**(217.28)**	**0.10**
					Operating Expenses						
911	854	3.23	3.23	0.00	Wakefield	6.48	6.37	(0.10)	38.71	38.58	(0.13)
586	568	2.01	2.04	0.03	Kirklees	4.03	4.05	0.02	24.32	24.32	0.00
360	346	1.16	1.23	0.07	Calderdale	2.33	2.40	0.07	14.08	14.08	0.00
433	420	1.34	1.35	0.01	Secure Services	2.68	2.68	0.00	16.17	16.17	0.00
1,589	1,511	5.66	5.58	(0.08)	Barnsley	11.36	11.17	(0.19)	67.66	67.05	(0.61)
690	675	2.74	2.70	(0.05)	Support & Central Services	6.26	6.16	(0.10)	41.89	41.54	(0.34)
		0.29	(0.00)	(0.30)	Provisions	0.45	0.47	0.01	2.60	3.63	1.03
4,568	**4,374**	**16.44**	**16.13**	**(0.31)**	**Total Operating Expenses**	**33.57**	**33.30**	**(0.28)**	**205.43**	**205.38**	**(0.05)**
4,568	**4,374**	**(1.66)**	**(2.02)**	**(0.35)**	**EBITDA**	**(2.67)**	**(2.98)**	**(0.31)**	**(11.95)**	**(11.90)**	**0.05**

Budget Staff in Post	Actual Staff in Post	This Month Budget	This Month Actuals	This Month Variance	Income & Expenditure Account	Outturn Budget	Outturn Actual	Variance (Fav'ble)/ Adverse	Annual Budget	Forecast Outturn	Forecast Variance (Fav'ble)/ Adverse
WTE	WTE	£m	£m	£m		£m	£m	£m	£m	£m	£m
		(1.66)	**(2.02)**	**(0.35)**	**EBITDA**	**(2.67)**	**(2.98)**	**(0.31)**	**(11.95)**	**(11.90)**	**0.05**
		0.36	0.40	0.04	Depreciation	0.84	0.81	(0.03)	5.02	5.02	0.00
		0.23	0.23	0.00	PDC Paid	0.47	0.47	0.00	2.81	2.81	0.00
		0.00	0.00	0.00	Interest Paid	0.00	0.00	0.00	0.00	0.00	0.00
		0.00	(0.01)	(0.01)	Interest Received	0.00	(0.01)	(0.01)	0.00	(0.05)	(0.05)
		0.40	0.40	0.00	Impairment of Assets	0.40	0.40	0.00	0.40	0.40	0.00
4,568	**4,374**	**(0.67)**	**(0.99)**	**(0.32)**	**Outturn**	**(0.97)**	**(1.32)**	**(0.35)**	**(3.72)**	**(3.72)**	**0.00**

Income and Expenditure Summary

The Trust budgets have been updated and reflect the submission to Monitor in May 2013 of the Trust 3 year financial plan. The Trust surplus remains at £3.72m as notified to the Board in March 2013.

The forecast as at month 2 is that this target will be achieved.

The year to date position at month 2 reflects a £1,321k surplus which is £354k ahead of plan. Whilst this is a positive position at month 2 there are pressures emerging within individual Business Delivery Units (BDU's) particularly concerning out of area activity and expenditure on bank. BDU's are underway in reviewing these pressures and finding mitigating actions to ensure they can achieve a breakeven position by the end of the financial year.

CQUIN – The value attached to CQUIN in 2013 / 2014 is £4.7m and a risk assessment at the start of the year highlighted schemes where there was a potential risk of under achievement and the value associated with this was approximately £900k. BDUs have been identifying actions to ensure delivery of the targets and latest projections are that the risk is significantly lower. A detailed review will take place at Quarter 1 to ascertain performance against plan and this will be reported in July.

CIPs – The Trust has a CIP programme totalling £8.7m and whilst targets have been achieved year to date, some risks are being identified for schemes which are profiled to start late summer.

In summary, the overall position at month 2 is ahead of target but there are financial risks emerging which have been identified early and therefore mitigations can be identified to manage these to ensure delivery .of the financial target.

Income and Expenditure Detail

Healthcare Income

Income is slightly ahead of plan due to additional out of area income. This is overachieving by £80k however there is a shortfall within Barnsley BDU of £50k.

The CQUIN value for 2013 / 2014 is £4.7m. An initial risk assessment, conducted in April 2013, highlighted risks around full achievement of this target. Following the risk assessment, action plans have been identified in all Business Delivery Units to mitigate against this shortfall – these will be monitored through the monthly Executive performance review and reported to Trust Board.

Expenditure Budgets

The current forecast position presents an overall Trust breakeven position. This assumes that risks will be mitigated and any potential underspends will be utilised within the organisation. This will be assessed within Quarter 1.

- Wakefield BDU – The year to date position is £103k underspent. This is due to pay underspends within Adult Community Services and Specialist Services. The BDU forecast is £132k underspent.

- Kirklees BDU - The year to date position is £21k overspent. This is due to high bank spend in month, specifically within Acute Inpatients. The BDU have identified actions to mitigate against this and the BDU forecast is a breakeven position.

- Calderdale BDU - The year to date position is £75k overspent. This is due to high Out of Area costs incurred in May 2013. The BDU forecasts these will reduce from July onwards and is forecasting a breakeven position.

- Forensics BDU - The year to date position is £4k overspent. The BDU position has a small overspend within pay, currently offset by non-pay underspends and overall forecasts a breakeven position.

- Barnsley BDU - The year to date position is £189k underspent. This is being driven by vacancies and underspend on the out of area treatment budget. The forecast outturn position is an underspend of £606k

- Support - The year to date position is £100k underspent. This consists of both pay and non-pay underspends and is across a number of directorates. The BDU forecast underspend is £343k.

Summary Performance of Cost Improvement Programme

Delivery of Savings 2013/14

CIPs		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
		£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Wakefield BDU	Target	70	70	70	70	70	70	70	70	70	70	70	70	140	839
	Actual	70	70											140	839
	Variance	0	0											0	0
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	50	574
	Actual	25	25											50	574
	Variance	0	0											0	0
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	40	392
	Actual	20	20											40	392
	Variance	0	0											0	0
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	76	460
	Actual	38	38											76	460
	Variance	0	0											0	0
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	312	1,884
	Actual	156	156											312	1,884
	Variance	0	0											0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	252	1,510
	Actual	126	126											252	1,510
	Variance	0	0											0	0
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	253	506	3,038
	Actual	253	253											506	3,038
	Variance	0	0											0	0
Total	Target	688	688	689	736	737	737	737	737	737	737	737	737	1,376	8,695
	Actual	688	688											1,376	8,695
	Variance	**0**	**0**											**0**	**0**

Delivery of Recurrent Cost Improvement Plans

The table on page 6 illustrates the delivery of the recurrent cost improvement plans for FY 2013/14.

The recurrent target is £8.7m. This recurrent target represents a 4% saving against Trust healthcare income.

The year to date target for month 2 is £1,376k and each BDU is showing full achievement against the target. Whilst full achievement is being delivered there is a small amount of slippage ie £20k which is being managed non recurrently in year. BDU's are aware that whilst slippage may be managed by alternative or substitute schemes the target must be achieved recurrently by the end of 2013-14.

- Wakefield BDU – The year to date position includes slippage on 1 scheme related to a scheme concerning non pay (contract renewal re transport) budget. This is £20k against a target of £140k. In year the BDU will manage the slippage through non recurrent savings and is confident the recurrent target is achievable.
- Kirklees BDU – Year to date schemes are on track, and whilst some risks have been identified, the forecast at this stage is full achievement of the target.

  Calderdale BDU – Year to date schemes are on track, and whilst some risks have been identified, the forecast at this stage is full achievement of the target
- Secure Services – The year to date and forecast position is full BDU achievement.
- Barnsley BDU – The year to date and forecast position is full BDU achievement.
- Support – The year to date and forecast position are full BDU achievement.

<u>Further Risks</u>

The above summary demonstrates that BDU's are on target and where schemes are slipping substitutions are being identified.

However there are some CIP schemes which are due to start in July (E Rostering) and risk are being highlighted at this early stage concerning the full achievement of the target. A detailed review will take place following implementation and risks quantified along with mitigating actions or alternative CIP schemes identified.

Other Key Indicators

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	May 2013 Actuals		Annual Plan Qtr 1	
Metric	Score	Rating	Score	Rating
EBITDA margin	7.7%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.0%	5	4.5%	5
I&E surplus margin	2.4%	4	1.9%	3
Liquid ratio	25	4	26	4
Weighted Average		4.1		3.9

REVISED
Financial Risk Rating 2013 / 2014

	May 2013 Actuals		Annual Plan	
Metric	Score	Rating	Score	Rating
Liquidity	4 days	4	0.7 days	4
Capital Servicing	5 times	4	5 times	4
Weighted Average		4		4

The Monitor Financial Risk Rating (FRR) is 4.1 against a planned position at the end of Quarter 1 2013 / 2014 of 3.9.

- EBITDA margin scores 3 in line with plan
- As a result EBITDA plan achieved scores 5 against a target of 5.
- Return on Assets remains on target at 5.
- Surplus margin scores 4 which is ahead of plan.
- Liquidity Ratio scores 4 against a plan of 4.

Overall the current Financial Risk Rating is higher than planned for the end of Quarter 1 as the I& E surplus is rated as 4 compared to the planned 3. The threshold for this metric is 2%.

As part of the Risk Assessment Framework these Financial Risk Ratings will be revised in 2013 / 2014, initially in shadow form. The current 5 ratings will be replaced by the 2 highlighted in the table to the right.

These have a rating matrix of 1 to 4 with 4 being the highest. For both Annual Plan and current performance we would be rated at 4.

Analysis of Expenditure by Type

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(6.7)	(1.1)	(1.2)	(0.0)	
	Recharges	(4.3)	(0.8)	(0.9)	(0.1)	
Non-healthcare Income Total		**(11.0)**	**(2.0)**	**(2.0)**	**(0.1)**	
	Admin & Clerical	26.8	4.5	4.4	(0.1)	1
	Agency	2.3	0.4	0.5	0.0	2
	Ancillary	7.2	1.2	1.2	(0.0)	
	Medical	19.4	3.2	3.1	(0.1)	1,3
	Nursing	81.6	13.7	13.3	(0.4)	1
	Other Healthcare Staff	32.9	5.6	5.2	(0.3)	1
	Other Pay Costs	(4.6)	(0.9)	0.0	0.9	4
	Senior Management	1.4	0.2	0.2	(0.0)	
	Social Care Staff	2.4	0.4	0.4	0.0	
Pay- Expenditure Total		**169.4**	**28.4**	**28.3**	**(0.1)**	
	Clinical Supplies	2.5	0.4	0.4	(0.0)	
	Drugs	3.8	0.6	0.6	(0.0)	
	Healthcare subcontracting	2.7	0.4	0.5	0.1	
	Hotel Services	2.3	0.4	0.5	0.0	
	Office Supplies	3.8	0.6	0.6	(0.1)	
	Other Costs	6.9	1.1	1.0	(0.1)	
	Property Costs	6.6	1.1	1.2	0.0	
	Service Level Agreements	6.1	1.0	1.0	(0.0)	
	Training & Education	0.9	0.1	0.1	(0.0)	
	Travel & Subsistence	5.4	1.0	0.8	(0.1)	
	Utilities	2.0	0.3	0.3	0.0	
	Vehicle Costs	1.5	0.3	0.3	0.1	
Non-pay Expenditure Total		**44.5**	**7.5**	**7.3**	**(0.1)**	
Provisions Expenditure Total		2.6	(0.3)	(0.2)	**0.0**	
Grand Total		**205.4**	**33.6**	**33.3**	**(0.2)**	

This table analyses operating expenditure by type of expenditure and reconciles to the operating expenses (including provisions) in the I&E summary.

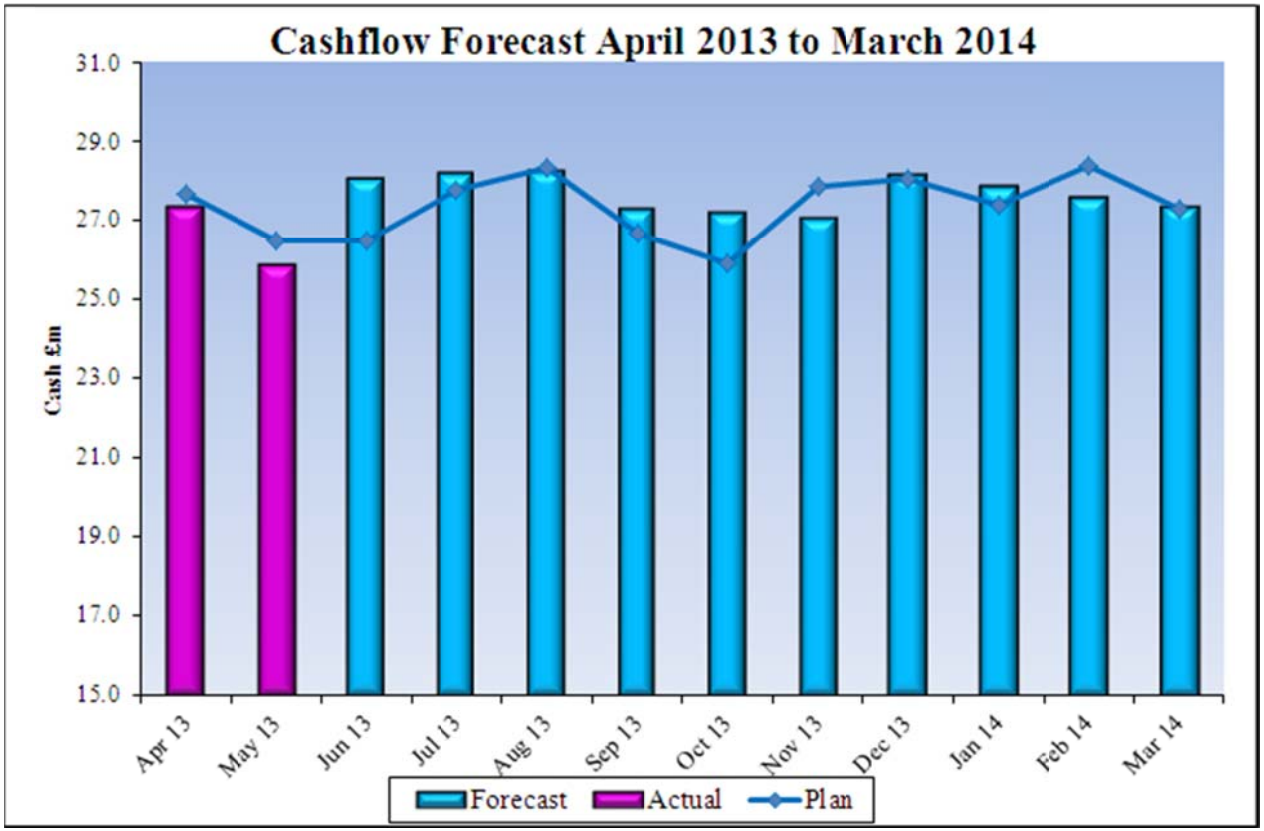
1. Actual expenditure on Administrative & Clerical, Medical and, Nursing staff is less than planned mostly as a result of vacancies. Some of these savings are offset by the cost of agency and bank staff.

2. Agency costs are marginally higher than planned. Spend year to date is Agency Medical costs £184k, Nursing £50k Social Workers £21k and Admin and Clerical £133k.

3. Savings on Medical staff relate to vacancies offset, in part, by agency expenditure.

4. This represents the recurrent staff vacancy factor. The savings requirement is £4.6m (approx. 2.5%) across the Trust and is planned to be achieved.

Rolling Cash-flow Forecast



This analysis shows the cash flow for the year as per the plan. The current plan is based on the forecast submitted to Monitor in May 2013.

The actual cash position for the month is £25.5m, which is £1.0m behind planned cash of £26.5m. This is due to a delay in payment from the CCG. This was an oversight and assurance has been given that future payments will be made in accordance with contract terms.

A further breakdown on the movement compared to plan is provided on page 12.

Reconciliation of Actual Cash-flow to Plan

	LTFM Plan £m	Actual £m	Variance £m	Note
Opening Balances	**29.9**	**29.9**	**0.0**	
EBITDA (Exc. non-cash items & revaluation)	2.0	3.0	**1.0**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.0	0.0	**0.0**	
Receivables (Debtors)	(3.2)	(3.0)	**0.2**	*2*
Trade Payables (Creditors)	0.5	0.1	**(0.5)**	*3*
Other Payables (Creditors)	(1.7)	(1.7)	**(0.0)**	
Accruals & Deferred income	0.5	(0.9)	**(1.4)**	*4*
Provisions & Liabilities	(0.3)	(0.3)	**0.1**	
Movement in LT Receivables				
Capital expenditure	(1.2)	(1.6)	**(0.4)**	*5*
Cash receipts from asset sales	0.0	0.0	**0.0**	
PDC Dividends paid	(0.0)	(0.0)	**0.0**	
PDC Received	0.0	0.0	**0.0**	
Interest (paid)/ received	0.0	0.0	**0.0**	
Closing Balances	**26.5**	**25.5**	**(1.0)**	

The plan reflects the May 2013 submission to Monitor.

At the end of the period the Trust is behind target against the plan.

Factors which increase cash position against plan:

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

2. Debtors are slightly lower than planned,specifically non NHS debtors.

Factors which decrease the cash position against the plan:

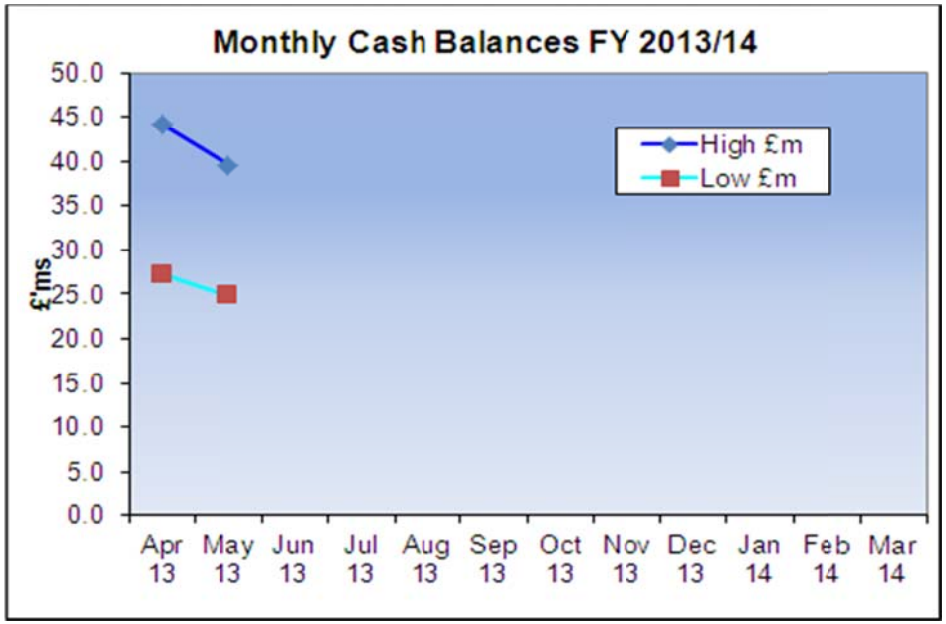
3. As the Trust continues to ensure compliance with the Better Payment Practice Code the level of creditors is lower than planned.

4. Accruals are lower than planned

5. Capital expenditure is ahead of plan in cash terms as, although the actual programme is in line with plan, capital creditors are lower than expected. This means invoices have been paid earlier than planned.

Cash Position

Cash Balances	LTFM Plan £m	Actual £m
Opening Balance	27.7	27.3
Closing Balance	26.5	25.5



The cash position at period end is £25.5m. The lowest balance of £24.9m was on the 14th. The highest balance for the month was on the 15th and was £39.6m. This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

The graph illustrates the high and low cash balances each month this financial year. The peak for the month is due to the NHS SLA income being received between the 13th and 21st of the month.

Resources Available for Capital Expenditure

Source of Funds	£m
Depreciation	5.35
Income and Expenditure Surplus	2.06
Disposal Proceeds	1.58
Total Resources for Capital Expenditure	**8.99**

Capital Resources

The capital programme for 2013/14 will be funded from cash available from depreciation, disposals and previously generated surpluses. Any surpluses generated during the year will not be required to fund this year's capital expenditure.

The Trust's capital plans reflected here are consistent with the 3 year Annual Plan submitted to Monitor in May 2013.

Capital Expenditure

Capital Expenditure Plans - Application of funds	Scheme Total £m	Annual Budget £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m	Note
Maintenance (Minor) Capital						
2012/13 Small Schemes c/fwd	0.00	0.00	(0.02)	(0.02)	0.00	
2013/14 Small Schemes	2.66	2.66	0.45	0.45	0.00	
Quality of Environment	2.23	2.23	0.00	0.00	0.00	
Total Minor Capital		**4.89**	**0.43**	**0.43**	**0.00**	
Newton Lodge Refurbishment & 10 Bed Extension	11.8	1.32	0.64	0.64	0.00	
IM&T	1.6	0.85	0.06	0.06	0.00	
Estate Strategy	19.9	1.94	0.00	0.00	0.00	
Total Other Schemes		**4.11**	**0.70**	**0.70**	**0.00**	
VAT Refunds						
TOTALS		**8.99**	**1.13**	**1.13**	**0.00**	

1. The total Capital Programme for 2013 / 2014 is £8,988k.

2. To date all schemes are in line with plan and are forecast to be fully delivered in 2013 / 2014.

3. Due to the nature of the capital programme expenditure is not expected to be incurred evenly throughout the year. The actual programme is based upon:

    - Qtr 1 19%
    - Qtr 2 15%
    - Qtr 3 21%
    - Qtr 4 45%

Note – Quarter 1 is higher than Q2 due to the completion of the Newton Lodge scheme.

Balance Sheet

	Actual at 31/03/13	Plan at 31/05/13	Actual at 31/05/13	Note
	£m		£m	
Non Current (Fixed) Assets	**69.2**	**107.0**	**107.0**	*1*
Current Assets				
Inventories & Work in Progress	0.6	0.6	0.6	
NHS Trade Receivables (Debtors)	1.4	1.0	2.1	*2*
Other Receivables (Debtors)	3.1	6.9	5.4	*3*
Cash and Cash Equivalents	29.9	26.5	25.5	
Total Current Assets	**35.0**	**35.0**	**33.6**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.5)	(3.0)	(2.5)	*4*
Non NHS Trade Payables (Creditors)	(3.9)	(2.3)	(2.3)	*4*
Other Payables (Creditors)	(3.5)	(3.5)	(3.3)	
Capital Payables (Creditors)	(1.3)	(1.2)	(0.8)	*5*
Accruals	(8.9)	(9.7)	(8.5)	*6*
Deferred Income	(0.8)	(1.0)	(0.8)	
Total Current Liabilities	**(20.8)**	**(20.6)**	**(18.3)**	
Net Current Assets/Liabilities	**14.2**	**14.3**	**15.3**	
Total Assets less Current Liabilities	**83.4**	**121.3**	**122.3**	
Provisions for Liabilities	(8.1)	(7.7)	(7.8)	*7*
Total Net Assets/(Liabilities)	**75.3**	**113.5**	**114.5**	
Taxpayers' Equity				
Public Dividend Capital	(42.0)	(42.0)	(42.0)	
Revaluation Reserve	(7.3)	(18.5)	(18.5)	
Other Reserves	(5.2)	(5.2)	(5.2)	
Income & Expenditure Reserve	(20.9)	(47.8)	(48.8)	*8*
Total Taxpayers' Equity	**(75.3)**	**(113.5)**	**(114.5)**	

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2013. The previous year end position is included for information.

The *Reconciliation of Actual Cash-flow to Plan* analysis on page 11 compares the current month end cash to the LTFM forecast for the same period.

1. Fixed assets include the April 2013 transfer of Estate from Barnsley (£37.9m) and are in line with plan.

2. NHS debtors are lower than planned with the exception of 1 block charge for May 2013 which was not paid in time. This has now been paid totalling £1.4m.

3. Other Debtors are currently higher than previously due to delays in payment from Councils for April & May 2013 block contracts.The plan included an assessment on the delay caused by increased Council payments which is planned to improve from June 2013.

4. Creditors continue to be managed in year in line with the Trust payment policy.

5. Capital payables continue at a low level due to the current capital programme. This is forecast to reduce further upon completion of the Newton Lodge scheme to increase again in Q3 and Q4.

6. When invoices are expected but haven't been received the Trust accrues for a known cost (which has a positive impact on cash until these are paid). Accruals are currently lower than planned.

7. Provisions remain broadly in line with plan with payments made in May 2013.

8. Year to date surplus plus reserves brought forward.

Better Payment Practice Code

	Number %	Value %
NHS		
Year to May 2013	97.3	95.5
Year to Apr 2013	98.0	99.9
Non NHS		
Year to May 2013	98.3	98.0
Year to Apr 2013	98.3	97.6

	Number %	Value %
Payments to Local Suppliers		
Year to May 2013	82.2	83.0
Year to Apr 2013	80.9	80.3

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

The performance against target for NHS invoices is 97.3% of the total number of invoices that have been paid within 30 days and 95.5% by the value of invoices. The shortfall relates to 1 invoice.

To date the Trust has paid 98.3% of Non NHS by volume within 30 days and 98.0% of Non NHS invoices by value.

With the current economic climate the Government has asked the Public Sector to try and pay Local Suppliers within 10 days, though this is not mandatory for the NHS. Given the Trust's position within the community this was adopted in November 2008.

To date the Trust has paid 82.2% of Local Suppliers invoices by volume and 83.0% of invoices by value within 10 days.

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 (£)
23/05/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2140664	118,321
03/05/2013	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership	2139640	61,276
23/04/2013	Switchboard SLA	Trustwide	Barnsley Hospital NHS Foundation Trust	2139026	45,249
02/05/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2139509	42,530
02/05/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2139607	42,530
29/04/2013	Membership Fees	Trustwide	Leeds and York Partnership	2139236	40,000
14/05/2013	CNST contributions	Trustwide	NHS Litigation Authority	8089317	28,302

Glossary of Terms & Definitions

- Recurrent – action or decision that has a continuing financial effect
- Non-recurrent – action or decision that has a once-off or time limited effect
- Full Year Effect – quantification of the effect of an action, decision or event for a full financial year.
- Part Year Effect - 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 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 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 had 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 part of the Recurrent Underlying Surplus.
- Cost Improvement Programme (CIP) – We only agree actions which are 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 once-off financial benefit. This Trust has historically only approved recurrent CIPs. 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 amortization. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of its services.
- IFRS – International Financial Reporting Standards, these are the guidance and rules by which financial accounts have to be prepared.

GLOSSARY

AWA	Adults of Working Age
AWOL	Absent Without Leave
BDU	Business Delivery Unit
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages & Pathway Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician rated outcome measure
CRS	Crisis Resolution Service
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
Inf Prevent	Infection Prevention
KPIs	Key Performance Indicators
MAV	Management of Aggression and Violence
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
OPS	Older People's Services
PCT	Primary Care Trust
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSA	Public Service Agreement
PTS	Post Traumatic Stress
Sis	Serious Incidents
SU	Service Users
TBD	To Be Decided/Determined
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 June 2013
Agenda item 7.3(i)

Title:	**Francis II and 'Patients First and Foremost' organisational review and action**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	To provide assurance that there has been an appropriate organisational response to the Francis Report in terms of communication, review, gap analysis and identification of action.
Vision/goals:	The response to Francis touches on all Trust values.
Any background papers/ previously considered by:	There has been a previous presentation of the Trust's approach and review by Trust Board. A paper has been received and considered by the Clinical Governance and Clinical Safety Committee on 17 June 2013.
Executive summary:	The Francis II report and the Government's response 'Patients First and Foremost' have been summarised and communicated Trust-wide via networks, workshops and material made available on the intranet. Review and direction for the organisational response has occurred at Trust Board (including Clinical Governance and Clinical Safety Committee) and Executive Management Team meetings and assurances have been provided to commissioning bodies that the organisation is responding appropriately to Francis. Two workshops were completed in April 2013 involving a cross-section of staff across the Trust enabling reflection and staff feedback. This has been followed by review and discussion at extended EMT in May 2013. The Members' Council received a presentation from the lead Director on the Trust's approach to addressing the Francis recommendations in May 2013 and will specifically review the recommendations relating to the roles/responsibilities of governors at its meeting in July 2013. A specialist leads assurance review and gap analysis against the Francis recommendations was completed in May 2013. This work entailed consideration of the implications of each recommendation to reach an informed judgement as to the organisational assurance level. The process also included identification of existing workstreams where any indicated action might be placed. The paper considered by the Clinical Governance and Clinical Safety Committee describes the key messages from staff which include: • poor staff feedback, failure to effectively 'close the loop' and enable learning; • a majority of staff demonstrate compassionate care but there remain individuals and some teams whose behaviour should be challenged; • pressures around staffing levels and skill mix, inconsistencies around support, training and expectations, team leaders unable to provide positive role modelling and supervision; • staff wary about raising concerns and whistleblowing; • a perceived conflict between openness and organisational reputation. Critical areas for action identified through the specialist review include a need to:

Trust Board 25 June 2013
Agenda item 7.3(ii)

Title:	Incident Management Annual Report 2012/13
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.
Vision/goals:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee.
Executive summary:	This report provides an overview of all incidents reported by the Trust during 2012/13, an analysis of serious incidents and an analysis of recommendations from completed serious incident reports. ➢ Incident reporting levels remain at a similar level to the previous year. ➢ There were no 'Never Events' reported in 2012/13. ➢ There were no homicides reported during 2012/13. ➢ 44 serious incidents were reported during 2012/13 of which the largest category was suspected suicide (31). Analysis using population size and National Confidential Enquiry data shows that a Trust of this size would expect to see between 26 to 36 potential deaths by suicide. ➢ The report will now be subject to detailed review by the newly established Clinical Reference Group as part of improved Incident Management Review processes.
Recommendation:	**Trust Board is asked to receive the report and note the contents.**
Private session:	Not applicable.

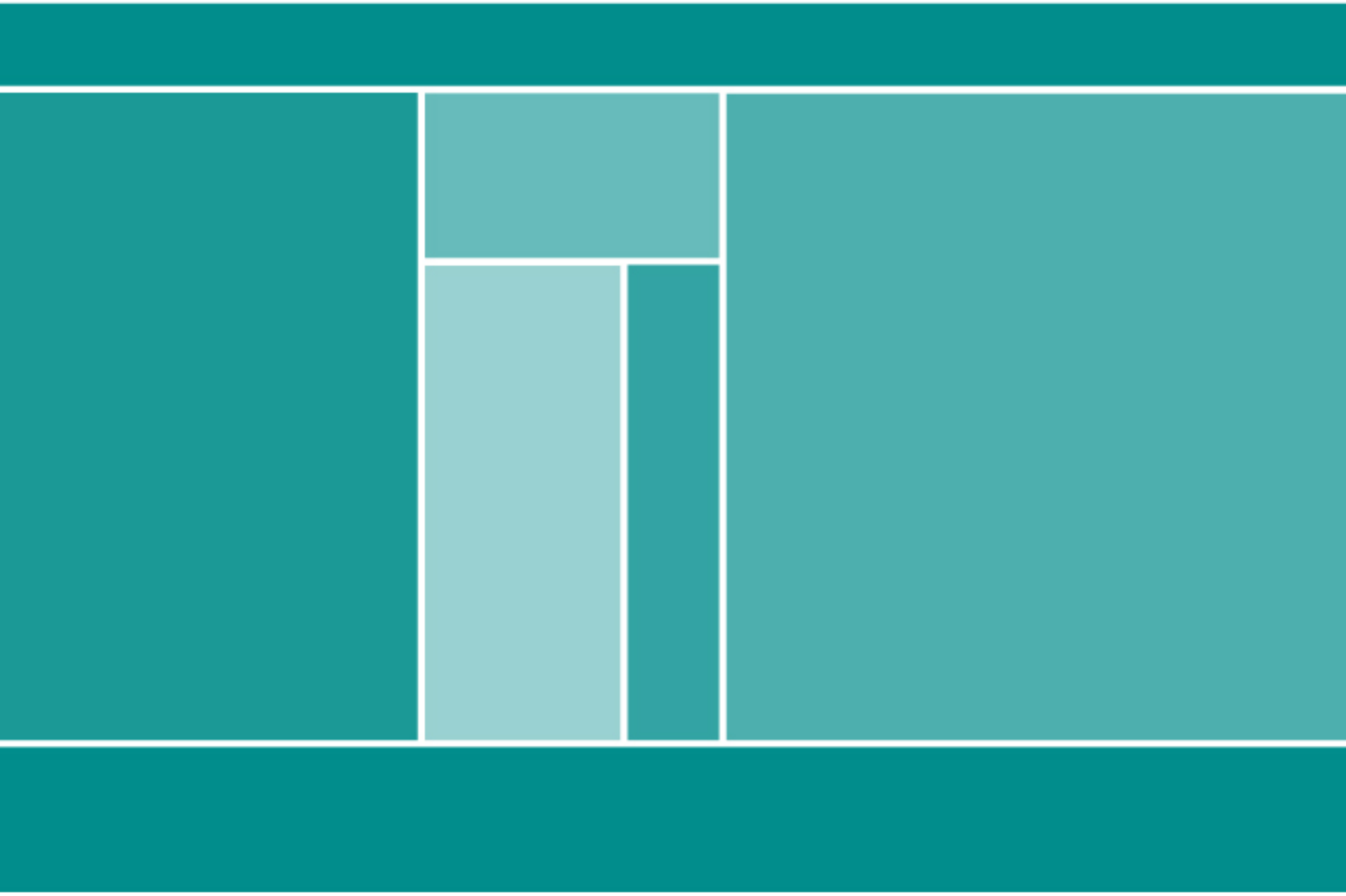
With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Incident Management

Annual report April 2012 to March 2013

Patient Safety Support Team



Executive Summary

This report provides an overview of all the incidents reported by the Trust, further analysis of serious incidents, and analysis of recommendations of completed serious incident reports sent to commissioners and work undertaken by patient safety support team for the period of 1st April 2012 – 31st March 2013.

The Trust reported 9949 incidents during the year; this was similar to last year. The range within a quarter is 2390-2552. The distribution of these incidents is in line with an established reporting process.

Never Events
No 'Never Event' incidents were reported by SWYPFT in 2012/13. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Homicides: Independent Reviews
There were no homicides reported in 2012/13

There are currently 4 homicide cases pending independent review.

2010/11	1 Kirklees BDU and 1 Barnsley Community Care Services.
2011/12	1 in Barnsley BDU and 2 in Kirklees BDU

One of the Kirklees cases has been subject to a domestic homicide review which was overseen by the Home Office.

The internal reports in relation to these cases are complete.

Serious Incidents (SI)
44 Serious Incidents were reported to the commissioning PCTs via the Department Of Health database – STEIS/unify. Serious Incidents are defined by the Strategic health Authority and include suspected suicide of service users, homicide by service users, never events, serious assaults and confidentiality breaches as well as attempted suicide (life threat/serious injury), and the unexpected death of an inpatient.

BDU population estimates and serious incident figures per 100,000

District	Population ONS –population estimates	Incident figures per 100, 000 population for 2012/3
Barnsley	235,976	3.4
Calderdale	202,841	3.96
Kirklees	400,920	3.2
Wakefield	337,152	4.15

The largest single category was suspected suicide (31) Analysis using population size and national confidential inquiry data shows that a Trust covering Barnsley, Calderdale, Kirklees and Wakefield would expect to see between 26 - 36 patient deaths by suicide per year. The report breaks this down by BDU and type and shows previous years for comparison.

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)	Suspected suicide reported on STEIS 2012/13
Barnsley	235,976	20-26/7	5-7	7
Calderdale	202,841	17-22/23	4-6	5
Kirklees	400,920	34-44/45	9-12	8
Wakefield	337,152	29-37	8-10	11

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

The performance of reporting, investigating and sending to report to the PCT has greatly improved over the year following investment of a team of lead investigators.

Analysis of Serious Incidents
(This part of the report covers analysis of 50 SI investigation reports completed between April 2012 and March 2013. The date range of incidents is 2011-2012).

Learning takes place at a number of levels, from individual staff reflection and learning to organisational changes being made. All SIs are subject to investigation using principles of Root Cause Analysis in accordance with national good practice guidance.

This report includes analysis of SIs Trust wide by number, type of SI, type of service and also by BDU. An analysis of recommendations including the type and number in each BDU and service area to indicate the learning from SI investigations has also taken place across the care pathway. The report also gives examples of the action that has taken place as result of analysing and learning from individual incidents and clusters.

2012/13 has been a challenging year for Patient safety support team, and this work continues in 2013/14

- Completing roll out of Datixweb in Barnsley BDU
- Bringing together resources and staff including policies and practice.
- Releasing resources agreed through the cost improvement programme
- Working with the BDUs in developing effective systems for investigation and learning from Serious Incidents.
- Reviewing incident data reports produced by the team to ensure they meet requirements and are cost effective.

CONTENTS

1. Introduction

The report has 3 sections

1. It includes a summary of **all** reported incidents from 1st April 2012 to 31st March 2013. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/ analyse incident reports within Trust wide Action Groups (TAGs) that the patient safety support team have assisted in setting up. In addition an annual audit of suspected suicides and undetermined deaths is undertaken by the Trust, and the 2012/13 report is currently being completed.

2. Learning from incidents, this section includes analysis of serious incident recommendations from completed reports submitted to commissioners between April 2012 to March 2013 Appendix 1 shows some data in relation to each BDU.

3. This report provides a summary of the work undertaken by the patient safety support team in relation to incident management and the development plans for the next year

The report is on the work of the Patient Safety Support Team and the data the team produces to support the BDUs to undertake learning from incidents. BDUs are in the best position to demonstrate the practical application of this, however there are some examples documented within the report.
The report must also be considered with the undetermined death audit which provides detailed information in line with national confidential inquiry data.

2. Summary of incident reporting (all severity grades) in 2012/13

a. Introduction

This section provides an overview of all incident reporting and management (all severity grades) from 1st April 2012 to 31st March 2013.

Quarterly incident management reports provide additional 'rolling' updates and analysis and these have been sent to BDUs and Clinical governance and clinical safety committee.

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

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

reported incidents which are severity graded as red are externally reported as a Serious Incident (SI) to the commissioning PCT via the DOH database STEIS.

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

All incidents graded red are classed as Serious Incidents and are reported to the PCT via the DOH database STEIS. These incidents are also subject to an investigation using the principles of RCA, in accordance with national good practice guidance and where required an action plan to address recommendations for improvement and learning.

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

b. Incident management reports and data provided

Incident management reports and data are prepared for a range of Trust meetings, groups and managers, by the Patient Safety Support Team, Specialist Advisers or operational managers who have access to reported incidents and report functions on Datix. Aggregated incident reports including comparative data are provided to Trust Board, Committees, the Executive Management Team, Trust Action Groups, Business Delivery Units and sub-groups, from which peaks and trends can be identified and explored.

The data provided has included breakdown and analysis of incidents, which can be by type, category, sub category, severity, date, time of day, service, team/unit, person and location of incident. Some of these reports include information about the lessons learned from SI RCA investigations.
The following are examples of the key reports that have been provided:

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

c. Total numbers of Trust-wide incidents reported in 2012/13

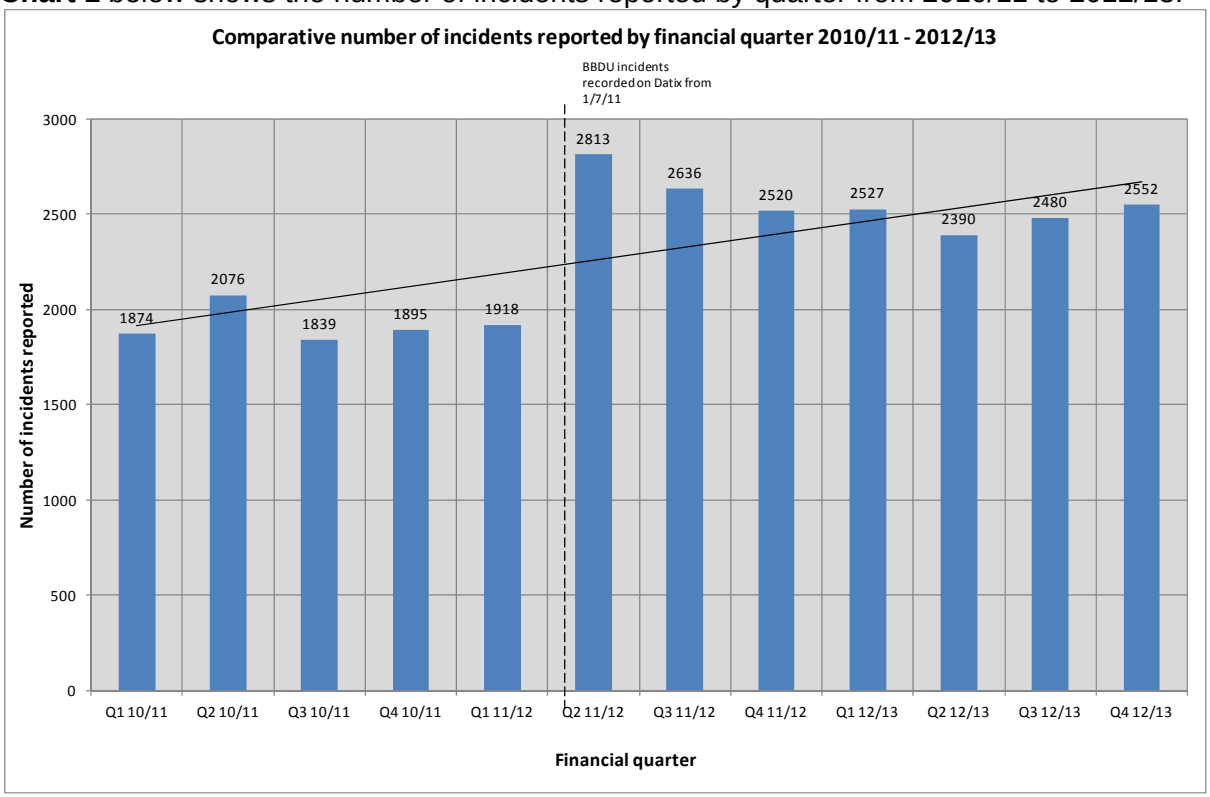
Incident reporting management and learning is a key element of an organisation's reporting and safety culture. A high level of incident reporting, particularly of less

severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety).
With the Trust changing profile of services it is difficult to compare with previous years.

Chart 1 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years. In each year there is a fluctuation from quarter to quarter with a range of 1874 to 2813 incidents being reported by quarter.

There has been a gradual overall increase in the number of incidents reported since the current reporting system was established in 2003/04, although this has not always been a year-on-year increase. In 2012/13 a total of 9948 incidents were reported, a minor increase of 89 compared with 2011/12.

Chart 1 below shows the number of incidents reported by quarter from 2010/11 to 2012/13.



More generally there are a number of other factors that can create fluctuations in incident reporting figures including:

- A change in the actual number of incidents occurring. Further examination of peaks in reported incidents previously has indicated that individual service user presentation factors are usually the underlying explanation
- Previous analysis has shown that violence and aggression incidents are particularly subject to peaks if an individual service user is presenting with very disturbed behaviour for a period of time. These cases have often then been proactively managed to develop more appropriate plans or placement.
- Evidence from other organisations which have introduced Datix-web indicates an increase in the number of incidents reported following roll out.
- A change in service structures such as a reduction in inpatient beds is likely to lead to a fall in the number of incidents, because inpatient units report the highest number of incidents.

- Proactive work to reduce incidents can have an impact on the number of incidents reported. For example there has been a lot of work undertaken in the Trust in response to serious incidents, falls, management of medication errors and violence and aggression.
  - Changes in reporting requirements – e.g. CQUIN data supported additional reporting
  - Impact of training and awareness increases incident reporting

d. Severity grading of incidents

All incidents are severity graded using the Trust's risk grading matrix to give a red, amber, yellow, green grade. Red is the most serious and always classed as a Serious Incident, green is the least serious. **Charts 2 and 3** show a breakdown of all incidents reported by severity and as a percentage of the total number reported in 2012/13 and in 2011/12

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

Chart 2 Incidents reported by severity 2011/12 (includes Barnsley BDU 1/07/11*)*

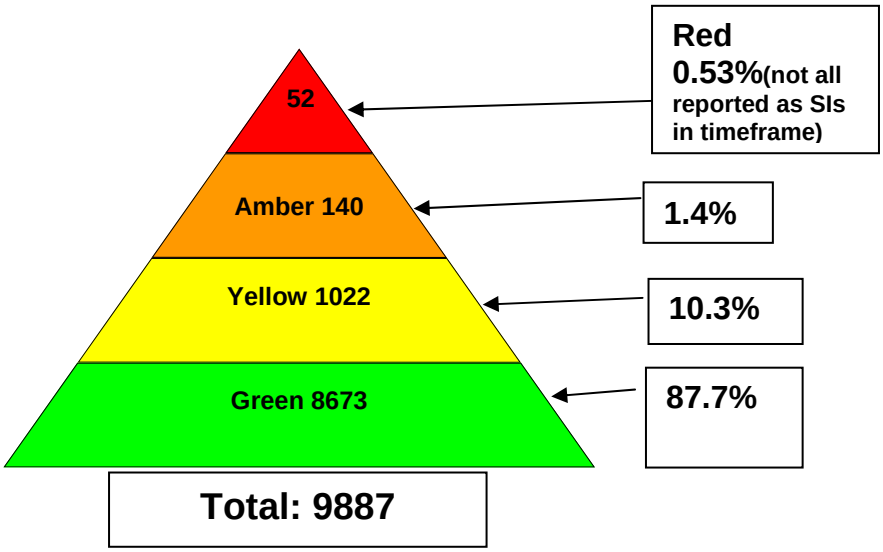
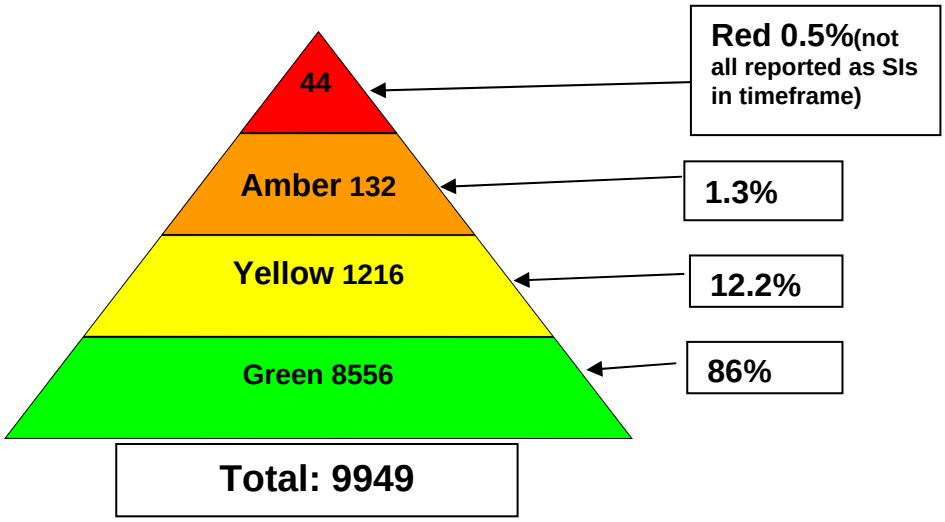


Chart 3 Incidents reported by severity 2012/13



Charts 2 and 3 Show the spread of severity rating across the incidents during the last two years. There has been no significant change during the last two years This profile is consistent with the 'expected' pyramid for reported incidents for the second year in a row, which is that more reported incidents would be severity graded the lowest (green) than any other severity grading.

The following additional points are worthy of note:

- The total number of incidents graded red and amber are relatively small as a proportion of the total number of incidents reported.
- Both red and amber percentage are down although only minimally

e. Results from Staff Survey 2012

There were a few questions asked within the survey which provided direct feedback on staff view of the incident reporting system

The 2012 Staff survey reported that the Trust had remained above average at staff reporting errors, near misses or incidents witnessed in the last month

Staff also reported a significant increase in the Fairness and effectiveness of incident reporting procedures

One area to further examine with the BDUs is the Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month. This indicator showed our staff were seeing more incidents that the national average. It is difficult to unpick what to conclude from this, is it that our staff are recognising more incidents than other similar Trusts or this could indicate that we are not learning and putting in preventative measures from patient safety incidents.
An action plan has been developed which has included further examination of how sharing the learning of all incidents can be communicated to staff. The learning events for red incidents have been well received. This will require the BDUs to consider this at all levels in the organisation.

3. Serious Incidents (SIs) analysis

a. Introduction

This section includes an analysis of Serious Incidents reported between 1st April 2012 ad 31st March 2013.
The Trust has robust processes in place to report and investigate serious incidents, based on the guidance provided by Yorkshire and the Humber Strategic Health Authority and the National Patient Safety Agency.

b. Definition and reporting SIs

Serious Incidents are incidents which meet the specific criteria as defined by the Strategic Health Authority. There is a requirement that these incidents are reported on the DOH database, STEIS, and are subject to an internal investigation by the Trust. Some require further independent review. The Trust's reporting, investigation and learning from SIs is externally monitored by the PCTs and to some extent the SHA). All

Trust incidents severity graded red using the Trust's risk grading matrix are reported as an SI to the commissioning PCT.

From April 2013 Clinical Commissioning Groups or NHS England Local Area team for specialised commissioned services will monitor incidents and action plans. Some of this has been delegated to the Clinical support unit (CSU) . The reporting will also include some amber incident in relation to pressure ulcers grade 3 and 4.

The SI criteria, reporting and external monitoring process means that there are potentially 3 dates associated with an SI – the actual incident date (if known), the date the incident is recorded on Datix and thirdly, the date the incident is reported on the DOH database STEIS, when it has been confirmed as an SI. There could be differences and gaps between these dates for number of reasons, for example:

- Suicide by a person in current contact with Trust services or within 6 months from discharge from Trust services is reportable as an SI. However the Trust may not be made aware of the suicide until some time after the event, and in the case of the suicide of a discharged service user sometimes months afterwards
- The cause of death may be thought to be due to natural physical causes and only confirmed or suspected as due to suicide or a patient safety incident some time afterwards
- Information about an incident may become available after the event, or may change – so the date of the incident and the date it becomes reportable as an SI could be different. For example the medical condition of a service user or staff member may be unclear for some time after an incident.

The Trust along with other Trusts bases its SI data on the date the incident was logged on the STEIS system and reported to the PCT. This is because:

i) To ensure consistency with the PCT, which monitor and count SIs based on the date the event was reported on the DOH database, STEIS.
ii) There can be significant differences in the incident date and the date the incident is reported as an SI ((for the reasons listed above)
iii) The data the Trust uses has been analysed in this way since 2003; to change this would affect comparative data.

c. Analysis of SIs

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

During 2012/13 a final total of 44 Serious Incidents (all graded red on the Trust's severity grading matrix) were reported to the commissioning PCTs via the DOH

database STEIS/Unify. Some incidents are reported, investigated and later de logged following additional information.
There were **no never events** reported. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Chart 4 below total number of serious incidents by financial year 2008/9 to 2012/13

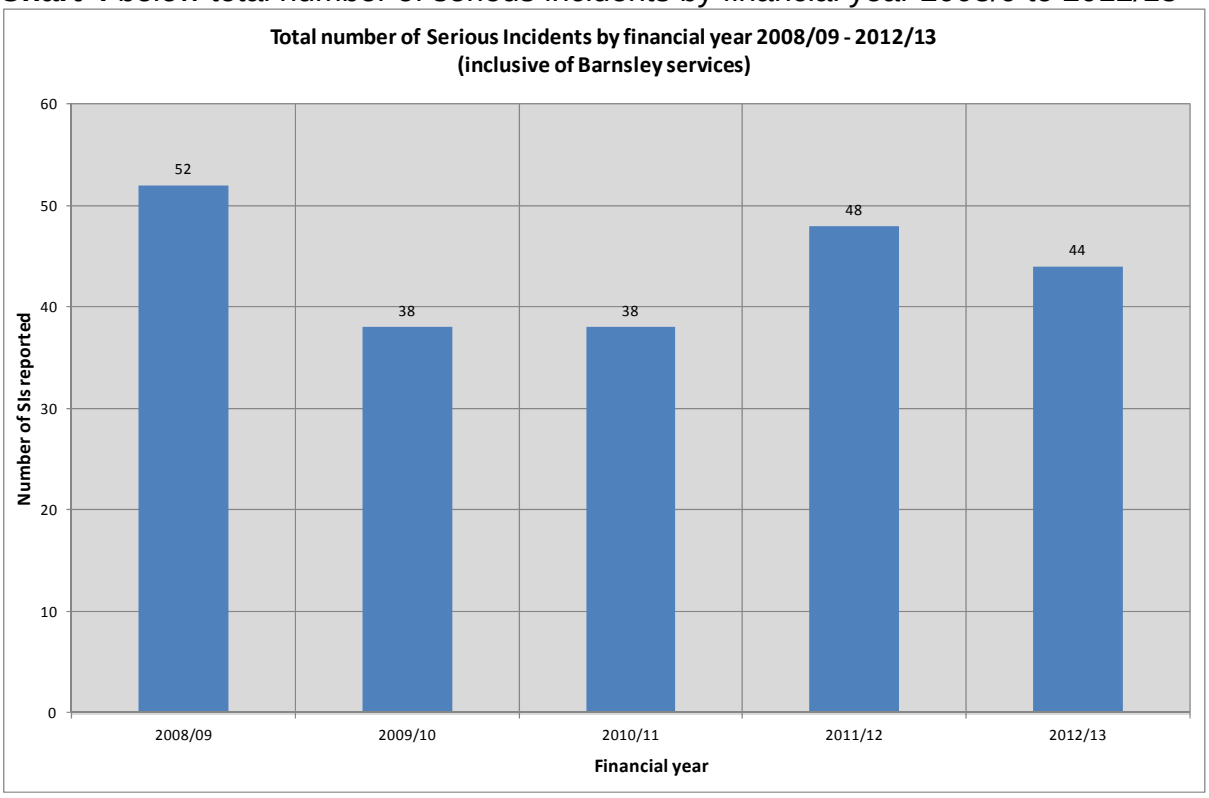


Chart 4 above shows the total number of SIs reported by financial year (based on date reported as an SI on STEIS) from 2008/09 to 20012/13. Barnsley BDU data is included from 2008/09 to enable comparison. This chart shows that there are fluctuations in the number in different years. The number reported in 2011/12 is higher than the previous 2 years but was comparable with the number reported in 2008. The Figure is NOT the number of apparent suicides or unexpected deaths but includes other SIs such as information governance. The financial year 2012/13 has 44 SIs which is average number across the 5 years but is slightly down on the previous year.
The occurrence of SIs on a yearly and month-by-month basis, by Trust-wide care group, by service and by BDU fluctuates. **Tables 1 and 2**, and **Charts 5 and 6** below show the 48 Serious Incidents reported in 2011/12 and the 44 Serious Incidents reported in 2012/13 by BDU, by month and by service. It is difficult to break down SIs in a comparative way due to the change in service; for example Barnsley adult mental health services are not organised on an age-based service structure (working aged and older age).

No SIs were reported by learning disability services in either year, which is consistent with previous years and with the client group. There were no SIs in community healthcare BBDU, this will change next year due to grade 3 and 4 pressure sores requiring STEIS reporting. As in previous years the majority of SIs occurred in working aged adult services (Calderdale, Kirklees and Wakefield BDUs), which is consistent

with the national picture. In Barnsley BDU the majority of SIs occurred in mental health services, which is consistent with previous years' data.

Table 1 2011/12 - the 48 reported SIs by BDU and Service

BDU	Totals	WAA	OPS	CAMHS	Forensic	Community Healthcare (BBDU)	Mental Health & SMS (BBDU)
Barnsley	**16**					2	14
Calderdale	**3**	1	2				
Kirklees	**20**	17	3				
Wakefield	**8**	6	1	1			
Forensic	**1**				1		
Non clinical	**0**						
Totals	**48**	**24**	**6**	**1**	**1**	**2**	**14**

Table 2 2012/13 - the 44 reported SIs by BDU and Service

BDU	Totals	WAA	OPS	CAMHS	Forensic	Community Healthcare (BBDU)	Mental Health & SMS (BBDU)
Barnsley	**8**						8
Calderdale	**8**	8					
Kirklees	**13**	11	2				
Wakefield	**14**	13	1				
Forensic	**1**				1		
Non clinical	**0**						
Totals	**44**	**31**	**3**	**0**	**1**	**0**	**8**

Chart 5: 2012/13 SIs by month and Business Delivery Unit -1/4/12-31/3/13

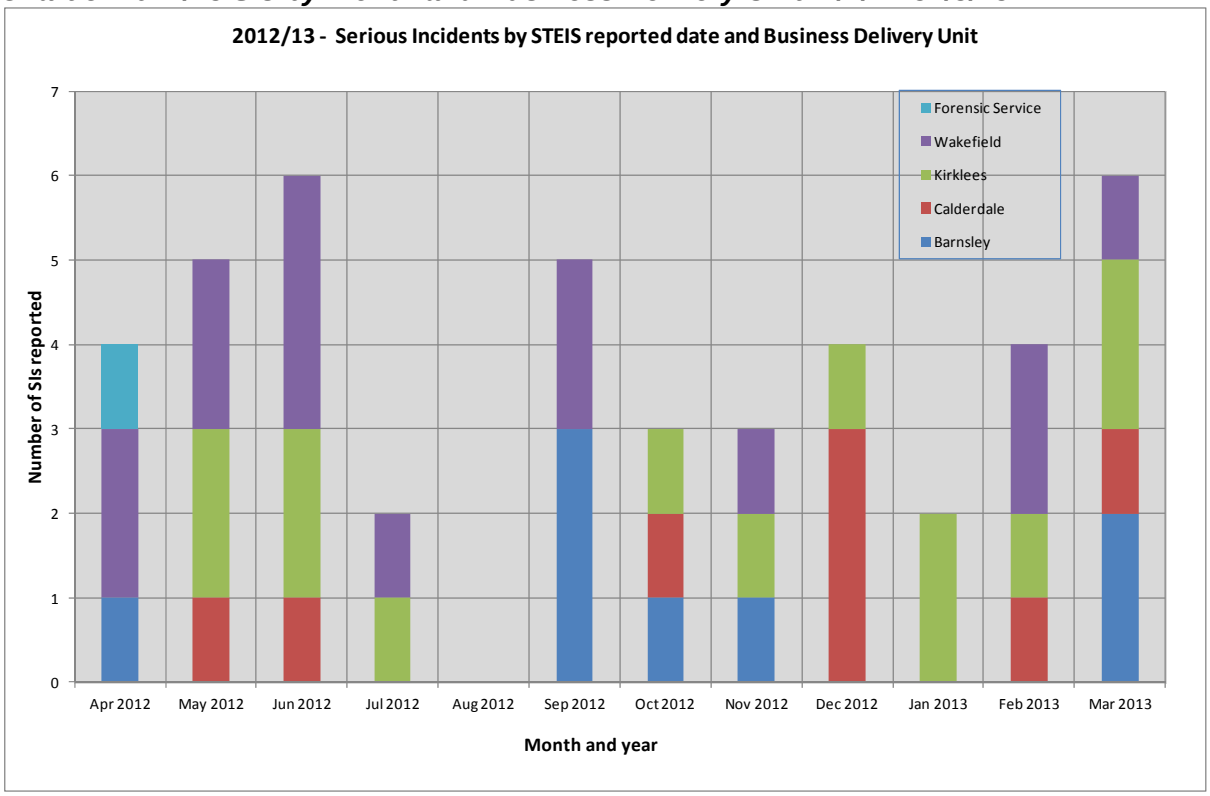
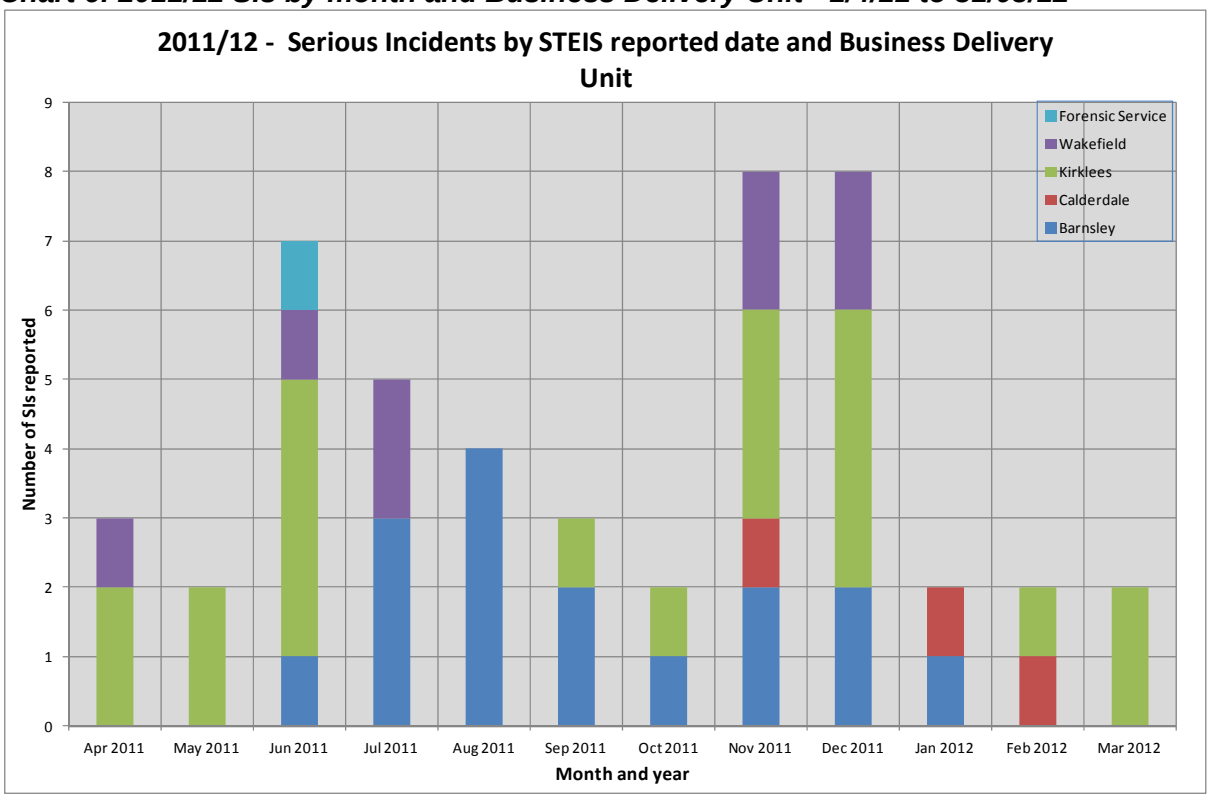


Chart 6: 2011/12 SIs by month and Business Delivery Unit - 1/4/11 to 31/03/12



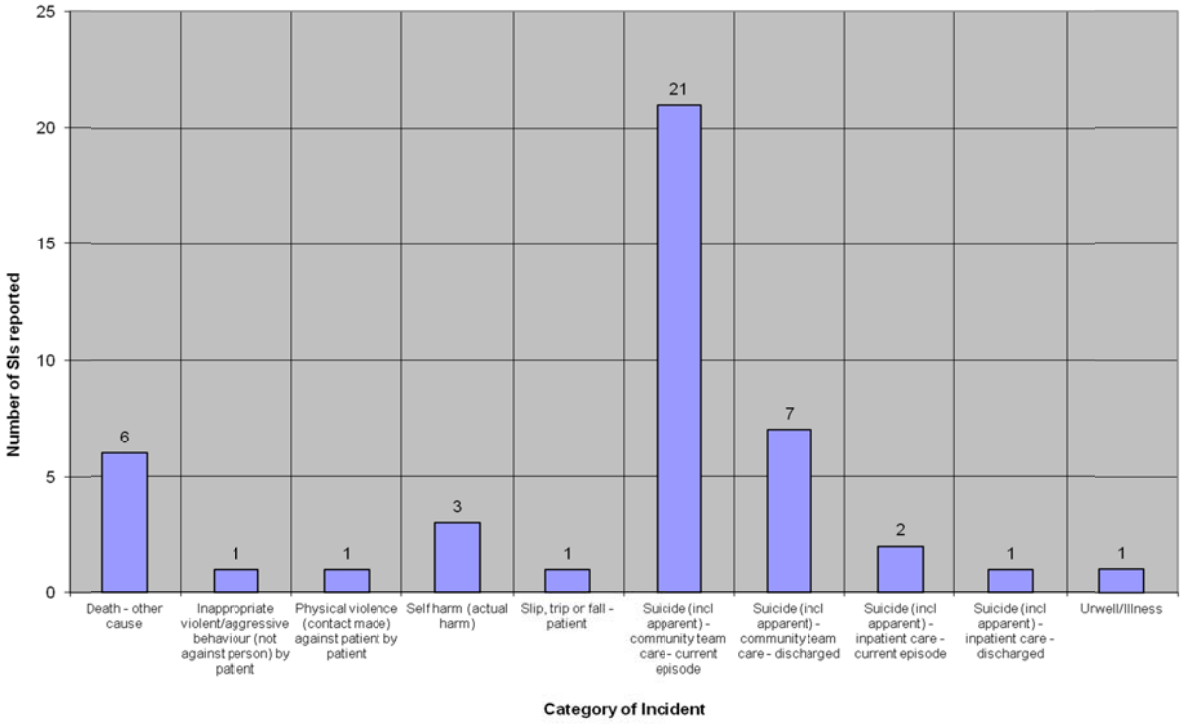
In 2011/12 the highest number were reported by Barnsley (16) and Kirklees (20) In 2012/13 the highest were reported by Kirklees (13) and Wakefield (14) BDUs. This is explained by BDU population sizes and service configuration; If the incidents are viewed per 100,000 population they are very similar as shown in **Table 3**.

Table 3*:* BDU population estimates and serious incident figures per 100,000

District	Population ONS –population estimates	Incident figures per 100, 000 population for 2012/3
Barnsley	235,976	3.4
Calderdale	202,841	3.96
Kirklees	400,920	3.2
Wakefield	337,152	4.15

Chart 7 on the next page shows the incident types as with previous years the highest single SI type is suicide or suspected suicide. These incidents are included in different 'types' because they might be suicide by service users in current contact with community services, service users discharged from mental health services with 6 months of the date of their death or an inpatient.

Chart 7- SI by type in 2012/13



Tables 4 and 5 provide a breakdown of SI by BDU and care group or service for both 2010/11 and 2011/12 for comparison. The results are similar for both years showing that working age adults services have most of the SI, this is in line with national reporting.

Table 4 2011/12 - the 48 reported SIs by BDU and Service

BDU	Totals	WAA	OPS	CAMHS	Forensic	Community Healthcare (BBDU)	Mental Health & SMS (BBDU)
Barnsley	**16**					2	14
Calderdale	**3**	1	2				
Kirklees	**20**	17	3				
Wakefield	**8**	6	1	1			
Forensic	**1**				1		
Non clinical	**0**						
Totals	**48**	**24**	**6**	**1**	**1**	**2**	**14**

Table 5 2012/13 - the 44 reported SIs by BDU and Service

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

The following provides further information about the incident types as shown on **Chart 7and Table 4 and 5:**

i) Suspected and actual suicide

This type of SI was most frequent in working aged adult services, and most suicides were by service users in contact with community services or discharged from services, which is consistent with national findings (NCI data). This is consistent with previous years.

ii) Homicides

In 2012/13 there were no homicides reported. In the previous 2 years there had been 5 (2010/11 -2 and 2012/13-3)

iii) Death /unwell– other causes

7 incidents were reported in this category. This has included patients that the cause of death is unclear or accidental e.g. a client recovered from a river by police, a suspected morphine overdose which was being used for pain management. The coroner has returned a verdict of misadventure in relation to one case. It can take a significant amount of time for the cause of death to be clear but this does not prevent the investigation being completed

iv) In patient suicides

There were 3 incidents, one took place on the ward, a second one took place while a person was on leave from the ward and the third individual had been discharged the day before.

v) Slips. Trip and fall

1 incident occurred where the patient incident resulted in a fracture neck of femur whilst in Trust care and subsequently died.

vi) Self harm/attempted suicide

During 2012/13 there were 3 very serious attempted suicides; two individuals have received significant physical intervention as a result of the incident.

vii) Physical violence - patient on patient

1 incident was reported which occurred on an older peoples ward involving 2 patients, neither had capacity and it is reported that one pushed the other resulting in a fractured neck of femur.

d. Analysis of suicide and suspected suicide incidents

All suicide and suspected suicide incidents involving a service user in current contact with Trust services, and service users discharged from services within the previous 6 months (if the Trust is made aware of this), are reported as a Serious Incident, in accordance with the Yorkshire and Humber SHA criteria. The Trust maintains close working arrangements with the Coroner's with regard to these cases.

Although the Trust undertakes an annual undetermined deaths audit, which provides a detailed analysis of these suspected suicide cases it is also important to provide some analysis of these cases in this report.

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

In 2012/13, as in previous years, the highest number of SIs in the geographically based BDUs (Barnsley, Calderdale, Kirklees, and Wakefield) was suspected suicide. This includes community, discharged and inpatient suicides/suspected suicides, and community undetermined deaths (which are reported as an SI because they could be a patient safety incident). The percentage of suicide, suspected suicide and undetermined community deaths of the total in 2012/13 is comparable with 2011/12 and with previous years. In 2011/12 the total was 29 of 48 (60%) and in 2012/13 the total was 31 0f 44 (70%).

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

The National Confidential Inquiry figures July 2012 indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2000 to 2010 there are approximately 10.04 suicides per 100,000 general population each year. (range 8.6-11.2)
- On average during 2000-2010 patient suicides accounted for 27% of the general population suicide figures (range 2.4-3)

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

Table 6: 2012/13 - Incidence of suicide by Trust BDU populations and NCI suicides rates

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)
Barnsley	235,976	20-26/7	5-7
Calderdale	202,841	17-22/23	4-6
Kirklees	400,920	34-44/45	9-12
Wakefield	337,152	29-37	8-10

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

Table 7 Suspected Suicides reported on STEIS each quarter 2012/13

District	Qu1	Qu2	Qu3	Qu4	Total
Barnsley	1	3	1	2	**7**
Calderdale	1	0	3	1	**5**
Kirklees	2	1	2	3	**8**
Wakefield	5	3	1	2	**11**
Forensic	0	0	0	0	**0**

Table 6 above shows the reported expected incidence of suicide in SWYPFT by BDU in the context of BDU populations and the NCI. These NCI figures do not reflect any social deprivation or other factors and are simply averages of the data collected. NCI 'patient' data includes all cases where the Coroner gave a verdict of suicide or an open verdict for any person who had been in current contact with mental health services, or in contact in the preceding 12 months. This is different to Trust SI data, which includes people in current contact with services, or in the preceding 6 months.

Tables 7 show the suspected suicide reported on STEIS, if this is compared to the expected incidence, it shows that Barnsley and Calderdale are within the expected figures. Kirklees is one below and Wakefield is one above. The Trust consistently is not an outlier but this does not make the Trust complacent in trying to learn and where possible prevent suicide.

Tables 8 and 9 below show the Trust's actual suspected suicide SIs figures for 2010/11 and 2011/12 by BDU, by care group / service and by the team or service that the person was in contact with either at the time of death or discharge

Table 8 2011/12 - Suspected suicides by BDU and service

Service in contact with	Barnsley		Calderdale		Kirklees		Wakefield		Total
	Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	
CMHT		3		1	5	1	2	1	**13**
IAPT/Mental Health Access		4			1				**5**
Crisis services		1	1		2				**4**
Early Intervention					2				**2**
Inpatient							1		**1**
Outpatient							1		**1**
Day services							1		**1**
Psychological therapy					1				**1**
Substance Misuse		1							**1**
Totals	**0**	**9**	**1**	**1**	**11**	**1**	**5**	**1**	**29**

Table 9 2012/13 - Suspected suicides by BDU and service

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

Information received from the National Confidential Inquiry into Suicides and Homicides by people with a mental illness (NCI) indicates that there was a national peak in suicide in 2008/09 in both the general population and people in contact with mental health services. This showed in the Trust data at the time. NCI data for 2011/12 and 2012/13 is not yet available so it is difficult to make like with like comparisons. The NCI data is up to 2010.

Deaths within community are similar to the previous year. There has been an increase in suspected suicides within crisis services this is in line with NCI which sent out a key message within the last report

- Services should now focus on safety in crisis resolution / home treatment. More evidence is needed on deaths of patients under these services.

There has also been 3 inpatient suspected suicide of inpatient, one of those episodes took place on the ward.

These suspected suicide cases are spread across all 4 of the geographically-based BDUs, with the highest number reported in Barnsley and Kirklees BDUs.
Most of these suspected suicide incidents involved people who were in receipt of community services – 28 of the 31 cases. Trust-wide (11 out of the 31) 35% of these incidents occurred in the CMHTs and (11 out of the 31) 35% occurred in crisis service. CMHTs carry the largest caseloads and the crisis/home treatment services undertake assessments and work with people who may present with high risks. All these cases were individually reviewed and actions to address any areas for improvement were identified.

Additional external review has taken place of a selection of the incidents involving crisis services to examine any further learning.

e. **Performance reporting of SIs.**

This year has seen a renewed focus on the process for reporting, investigating and sharing the learning from serious incidents Much of the planning and implementation has taken place with consolidation and review being the focus over the next few months.

The Trust has appointed a team of lead investigators, most coming into post in January 2013. A team of Medical Consultants have additional sessions to provide clinical support to the investigators. All of these staff have undertaken additional master class training in root cause analysis with a follow up session planned for November 2013.

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

As part of the contract there is a timescale to meet to deliver these reports at the end of 2011/12 the Trust had 18 investigations that were outside the timescale. At the end of March 2013 that figure had decreased to 5 overdue reports (all the overdue reports had agreed extensions). The delay is due to complexity of case, the appointed investigators picked up some unallocated cases

Table 10 Status of investigations into serious incidents reported between 1.4.12- 31.3.13:

	Barnsley	Calderdale	Kirklees	Wakefield	Forensic	Total
Incidents reported	8	8	13	14	1	**44**
Completed	7	5	11	14	1	**38**
Not overdue		1				**1**
Overdue	1	2	2			**5**

f. Feedback from Commissioners

Once the report is sent to the PCT it is quality checked by them to ensure it meets the required standard. The Trust have received few queries back from the PCTs. The reports have been signed off by commissioners as meeting the standards required. Many positive comments have been received re the quality and depth of the reports.

4. Independent reviews

a. Independent investigation

This year the Trust held one independent investigation in relation to a case that took place while care services were part of Barnsley PCT
The report was produced in March 2013

"*Overall, the Independent Team is satisfied that the internal investigation conducted by NHS Barnsley was of a reasonable standard and that the PCT Team did undertake a 'fearless and searching' review of the care and service provided to JK between 2004 and 2010. The effort of undertaking 40 interviews to try and make sure that there was sufficient understanding of JK's and his mother's care and treatment can only be commended."*

The investigation did produce some recommendation and an action plan has been developed, some of the recommendations have already been met.

One of the Kirklees cases below from 2011/12 has been subject to a Domestic homicide review this year and the report is currently with the Home Office for review. The Trust is awaiting confirmation as to whether this will also be subjected to another independent review.

b. Pending independent review cases

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

During 2011/12 to date one further Barnsley BDU homicide case and two further Kirklees homicide cases involving current service users or service users discharged within the previous 6 months have been reported.

3 of these cases are likely to be subject to an independent investigation commissioned by the CCG, the 4th incident is the one mentioned above which has been subject to Domestic Homicide Review which was reviewed as adequate.

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

5. Learning from Incident reporting

a. Introduction

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

- **Individual reflection following an incident** –an example of this is a Consultant who after being part of an investigation team thought about their communication with patients. The Consultant reviewed 10 sets of notes, set some standards and then following implementation they reviewed another set of 10 notes and involved the reception staff in a simple questionnaire about how involved they felt in the decision making. This Plan, Do, Study & Act cycle has resulted in individual change. This Consultant shared this learning at a medical audit meeting. Reflection often takes place within supervision sessions
- **Team reflection and action** - teams will undertake further analysis particular types of incidents, the forensic service have during the year requested and used more data on incidents of violence, safeguarding referrals and incidents where the police have been called. Performance and information have looked at data following system issues to understand the impact on clinical areas.
  Learning events following a serious incident allows all members involved to have the findings presented and assist in turning the recommendations into actions that will make a difference.
- **BDU –** Have quarterly reports on incidents which provide data to look at trends and performance information. Individual serious incident reports are shared at senior manager level for onward sharing through governance processes.
- **Trust level –** learning from incidents is reported through the BDU, TAGs, analysis of recommendations. The Incident review sub-committee when fully functioning will review wider trend and learning lessons. Annual reports often report on incident information e.g. health and safety
- **Specialist Advisors**- receive individual incident notification to enable them to provide support if necessary. Many undertake production of quarterly reports for TAGs and wider learning. Additionally each quarter the Trust's Specialist Advisors are asked to provide information on any significant learning, identified peaks and notable advice given within the period. This is then incorporated into the Trust's quarterly incident report, produced by the Patient Safety Support Team. During 2012/13 there was a number of issues raised where learning, good practice and improvements were noted: Below highlights a selection of information provided by Specialist Advisors.

Safe Medicines Management

In response to a number of incidents which involved hypnotics and benzodiazepines, the Safe Medicines Practice Group produced a safety bulletin regarding medicines at the interface as well as updating previous bulletins on missed doses and low molecular weight heparins. Staff member's attention was also drawn to the National Patient Safety Agency's (NPSA) Rapid Response Alert relating to the supply of critical medicines out of hours.

During the financial year the safe Medicines practice Group identified two common themes, these were:

A) Medication being issued or administered to the wrong person. As a result of such incidents the guidance on wrist bands produced by the NPSA was revisited. It was

noted that a number of wards throughout the trust had photos of Patients on prescription charts, to help address the issue.

B) A number of incidents relating to the prescribing, dispensing and administration of depot prescriptions were reported. In order to reduce such incidents the use of diaries and Rio to prompt administration dates were utilised.

Fire
As a result of non compliance with smoking policies at a large number of inpatient facilities throughout the Trust, the activation of fire alarms has become a regular occurrence. In order to address the issue there would be a review of the Smoking Policy. The Health and Safety Advisor would also check the provision of smoking shelters throughout the Trust. It was suggested that fixed cigarette lighters in external smoking compounds would reduce the requirement for other such lighters.

Tissue Viability
Root Cause Analysis documents (which are completed within Barnsley BDU for grade 3 and 4 pressure ulcers), were previously handwritten, these forms were often illegible. An electronic version of this document has been produced and is currently in use.

When reporting tissue viability incidents via Datix, it became apparent that there were no categories relating to incidents other than skin tears and pressure damage. Datix has subsequently been updated to provide such options.

Pressure ulcers to heels have been reduced by the purchase and use of heelpro heel protectors and repose boots. Nurses are also able to prevent existing pressure damage to heels becoming deeper by using the off loading devices as mentioned.

District Nurses in the Barnsley area have reported the inaccurate grading of wounds by the Acute Trust. This has resulted in the production (by both organisations) of a poster called Guidelines to Grading Wounds. This contains photographs and information to assist when grading such wounds.

Safeguarding
When staff attend crown court, coroner's court or family court, they will now ensure that they have the appropriate level of supervision or advice from the Safeguarding team prior to attendance. Staff will ensure that all recording keeping and documentation is of a high quality so that information sharing is effective. Incidents often occur at handover points due to incomplete or incorrect information.

6. Analysis of recommendations from completed SI reports (Trust wide)

The date range of the actual incidents these reports relate to is June *2011 and December 2012.*

This section includes an analysis of the recommendations made in the Serious Incident investigation reports **completed** between April 2012 and 31st March 2013. There were a total of 50 investigation reports completed during this time an increase of 13 reports from the previous 12 months (a result of the focus on timescales rather than an increase in incidents), which led to 237 recommendations being made. Four of these reports made no recommendations.

To give some context to the type of cases which were included these have been broken down first in **Table 11** by incident category, team and

Table 11 50 SIs sent to Commissioner 1/4/2012 – 31/3/2013 by incident category and team (grouped BDU)

	Self harm (actual harm)	Suicide (incl apparent) - community team care - discharged	Suicide (incl apparent) - community team care - current episode	Suicide (incl apparent) - inpatient care - discharged	Suicide (incl apparent) - inpatient care - current episode	Death - other cause	Homicide by patient	Total
Barnsley	**0**	**1**	**3**	**0**	**1**	**1**	**1**	**7**
Central Barnsley CMHT			1					**1**
Clark Ward, Oakwell Centre					1			**1**
Community substance misuse team			1				1	**2**
Specialist Health Learning Disabilities Service						1		**1**
Mental health access team (Primary care MH service)		1						**1**
North Barnsley CMHT			1					**1**
Calderdale	**0**	**2**	**3**	**0**	**0**	**2**	**0**	**7**
Beechdale Ward						1		**1**
Crisis Resolution Team		2	1			1		**4**
CMHT - West (OPS)			1					**1**
CMHT - Halifax (WAA)			1					**1**
Forensic Service	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Bronte Ward	1							**1**
Kirklees	**2**	**3**	**9**	**0**	**0**	**3**	**2**	**19**
Ashdale Ward						1		**1**
CMHT - Batley (WAA)			1					**1**
CMHT - South Kirklees (East) (WAA)			2					**2**
CMHT - Spenborough (WAA)		1	1					**2**
CMHT - South Kirklees (West) (WAA)			1					**1**
Early Intervention Service (Insight)			2				1	**3**
IHBTT (Kirklees Crisis Team)		2	2				1	**5**
Ward 19 - Priestley Unit (OPS)						2		**2**
Ward 18, Priestley Unit (WAA)	2							**2**
Wakefield	**1**	**2**	**9**	**1**	**1**	**2**	**0**	**16**
CMHT 2 - Airedale (WAA)						1		**1**
CMHT 4 - Pontefract (WAA)			2					**2**
CMHT - South Kirkby (WAA)		1						**1**
CMHT 1 - Wakefield North (WAA)			1					**1**
Crisis Resolution Team - Wakefield	1	1	1					**3**
Day Treatment Services - Pontefract			1					**1**
Outpatients Department			2					**2**
Priory 2				1	1			**2**
Rapid Access Service - Wakefield			1					**1**
Trinity 2						1		**1**
Vocational Team, Garden Street Centre			1					**1**
Totals:	**4**	**8**	**24**	**1**	**2**	**8**	**3**	**50**

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

Table 12 and 13 shows the number of recommendations by BDU, care group and service for both 2012/13 and the previous year 2011/12.

The number of recommendations attributed to a particular team or service is directly related to the service where the incident occurred. One incident report can generate a high number of recommendations.

Table 12-2012/13 – completed reports **(**50) Number of recommendations by BDU, care group and main service the person affected by the incident was in contact with

Service in contact with	Total	Barnsley		Calderdale		Kirklees		Wakefield		Forensic
		Com	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	Medium Secure
Crisis services	**69**			16		31		22		
CMHT	**57**		9	7	2	25		14		
Inpatient	**44**				2	17	10	12		3
Early Intervention	**23**					23				
Day services	**16**							16		
Outpatient	**8**							8		
IAPT/Mental Health Access	**6**		6							
Learning disability services	**6**		6							
Substance Misuse Team	**4**		4							
Rapid access	**3**								3	
Total	**236**	**0**	**25**	**23**	**4**	**96**	**10**	**72**	**3**	**3**
		25		**27**		**106**		**75**		**3**

Table 13: 2011/12 – Completed reports (37): Number of recommendations by BDU, care group and main service the person affected by the incident was in contact with

Service in contact with	Total	Barnsley		Calderdale		Kirklees		Wakefield			Foren -sic
		Com	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	CAMHS	
Inpatient	**22**	5	8			9					
Outpatient	**0**										
CRHTT	**33**		9			9		15			
CMHT	**52**		4			19	8	16	5		
IAPT/Mental Health Access	**20**		14			6					
Psychological therapy	**5**					5					
Substance Misuse Team	**1**		1								
Learning disability units	**8**										8
PICU	**11**							11			
Rehabilitation unit	**5**			5							
AOT	**4**							4			
CAMHS	**1**									1	
Total	**162**	**5**	**36**	**5**	**0**	**48**	**8**	**46**	**5**	**1**	**8**
		41		**5**		**56**		**52**			**8**

Table 14 and 15 show the incident type, BDU and care group for both 2012/13 and the previous year 2011/12.

Table 14 2012/13 Completed report (50) number of recommendations by BDU, care group and incident type – reports completed

Incident type	Total	Barnsley		Calderdale		Kirklees		Wakefield		Forensic
		Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	Medium secure
Suspected suicide	**156**		15	16	2	54		66	3	
Homicide	**29**		4			25				
Serious self harm	**24**					15		6		3
Undetermined death (community)	**23**		6	7			10			
Unexpected death (inpatient)	**4**				2	2				
Total	**236**	**0**	**25**	**23**	**4**	**96**	**10**	**72**	**3**	**3**
		25		**27**		**106**		**75**		**3**

Table 15: 2011/12 Completed reports (37) - number of recommendations by BDU, care group and incident type – reports completed

Incident type	Total	Barnsley		Calderdale		Kirklees		Wakefield			Forensic
		Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	CAMHS	Medium secure
Allegation against staff member	**9**									1	8
Absconded (not a never event)	**2**		1					1			
Suspected suicide	**106**		16	5		37	8	35	5		
Undetermined death (community)	**10**		5			5					
Unexpected death (inpatient)	**6**		6								
Information governance (IG)	**13**		7			6					
Infection control	**5**	5									
Serious self harm	**11**		1					10			
Total	**162**	**5**	**36**	**5**	**0**	**48**	**8**	**46**	**5**	**1**	**8**
		41		**5**		**56**		**52**			**8**

In 2011/12 most recommendations relate to incidents where the person had been in contact with working aged adult CMHT, CRHTT, IAPT/Mental Health Access and inpatient services (including PICU) – which is consistent with the higher number of incidents associated with those services. For 2012/13 recommendations continue to be high in relation to crisis services, CMHT and inpatient service. IAPT/ Mental health access have minimum recommendations as the number of incidents linked with those services reduced.

Table 14 and 15 show that for both years the Trust has analysed recommendations that the largest were in relation to suspected suicide incidents. This is unsurprising as this is the largest incident type.

In analysing the recommendations it isn't always straightforward to identify which issue-type a recommendation should be included in - some didn't easily fit into any type, and some could be included under more than one. The analysis undertaken has included each recommendation under the issue-type that seemed the best match.

As shown in **Table 16** when comparing the recommendations from last year the top 5 areas remain the same but in a different order.

Table 16 Ordinal list of recommendations 20011/12 and 21012/3

Recommendation type	2012/13	2011/12
Record keeping	1	4
Team/service roles, systems & mgt	2	3
Staff education, training, supervision	3	5
Care delivery	4	2
Care pathway	5	1

Table 17 2012/13 Type of recommendations by BDU and service

Recommendation type	Total	Barnsley		Calderdale		Kirklees		Wakefield		Forensic
		Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	Medium secure
Record keeping	**29**		6	4		11	2	6		
Team/service roles, systems & mgt	**27**			1	1	9		14	2	
Staff education, training, supervision	**25**		1	3		8	3	9		1
Care delivery	**23**		4	2		9	2	6		
Care pathway	**22**		4	2	1	12	2	1		
Organisational systems, mgt issues	**22**		2			12		8		
Risk assessment	**20**		4	2		11		3		
Carers/family	**18**		1	3		9		5		
Policy/procedure – in place, not adhered to	**15**				1	4		8	1	1
Communication	**9**		1				1	7		
Care coordination	**7**		1	2		2		2		
No recommendations	**4**		2					2		
Medicines mgt	**4**			1		1		2		
Other	**4**			1		3				
MHA, MCA & consent	**3**					3				
Patient engagement	**3**		1	1		1				
Environmental	**2**			1						1
Physical healthcare	**2**				1	1				
Info governance	**1**							1		
Staff attitude	**0**									
Totals	**240**	**0**	**27**	**23**	**4**	**96**	**10**	**74**	**3**	**3**
		27		**27**		**106**		**77**		

Table 18: 2011/12Type of recommendations by BDU and service

Recommendation type	Total	Barnsley (41)		Calderdale (5)		Kirklees		Wakefield			Foren -sic
		Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	CAMHS	
No recommendations	**2**	1	1								
Care coordination	**4**						2	2			
Care delivery	**24**	1	14			3		6			
Care pathway	**27**	3	5			6	2	9	1		1
Carers/family	**9**			2		2		5			
Communication	**2**					1		1			
Environmental	**4**										4
Info governance	**5**					4		1			
MHA, MCA & consent	**1**							1			
Medicines mgt	**0**										
Organisational systems, mgt issues	**11**		3	1		2	2	3			
Patient engagement	**3**					3					
Physical healthcare	**0**										
Policy/procedure – in place, not adhered to	**6**		1			1		3	1		
Record keeping	**19**		4			8	2	5			
Risk assessment	**5**			1		3		1			
Staff attitude	**0**										
Staff education, training, supervision	**12**		1			4		5	1		1
Team/service roles, systems & mgt	**23**		4	1		11		4		1	2
Other	**5**		3						2		
Totals	**162**	**5**	**36**	**5**	**0**	**48**	**8**	**46**	**5**	**1**	**8**
		41		**5**		**56**		**52**			**8**

Overall the BDUs need to ensure that recommendations are SMART and that evidence is collected against each recommendation. A summary of the evidence needs to be added to the action plan section on Datix. This will assist in greater analysis in real time. The quality of data is currently variable.
Examples of the recommendations which are included in each type are provided below along with some example of the work being undertaken to address this, this is not a comprehensive outcome from the recommendations:

1. **Care pathway – referral, access, discharge, transition between agencies, services & related communications (22)**

A high number of the recommendations in this type were in relation to discharge and transfer.
The other recommendations were in relation to clarity in pathways e.g. communication and transfer with acute hospital, access for individuals with learning disability and mental health issues into acute mental health beds

Action in response

- During 20012/12 a task and finish group met on several occasions to review and re issue the discharge policy.
- A group has been set up to work with the acute Trusts to develop a policy on expectations for transfers and communication.
- A number of operational policies have been updated to provide clarity to teams.

- Trust wide the transformational work is examining the care pathways

2. Care delivery - assessment, care planning and review, diagnosis, treatment & other care delivery (25)

The recommendations in the type were varied but many were in relation to ensuring robust reviews and updating care plans e.g. ensure changes in medication are reviewed, clear communication of next stage of care, ensure communication and understanding of plan with service user.

Action in response

- Audit of care plans
- Triage template based on Sainsbury's risk assessment in situ for SPA to identify decision-making process.
- Communication and discussion within team meetings

3. Care coordination and care registration - CPA and other (7)

These issues related to ensuring that care coordination and CPA processes are followed and implemented effectively. They link with clarity of care coordinator role and that the CPA policy is being adhered to.

Action in response

- Work undertaken with performance and information re CPA a review monitoring has supported addressing some of the actions raised.
- Tightening up on processes.
- Kirklees is planning a joint workshop with CPA manager to assist in role clarification

4. Risk assessment, management & contingency (20)

Again the breath of area of risk assessment recommendations was wide. It included audit of process, reviewing the risk assessment tools used in teams, potential high risk times such as bank holidays and ensuring contingencies are in place.
Clarity about traffic light systems in team, ensuring level 2 risk assessment is completed as soon as possible following admission, improving the recording of risk assessments

Action in response

- Guidance has been issued.
- Risk tools are being evaluated by teams

5. Record keeping & documentation (29)

Record keeping had the highest number of recommendations this year. The recommendations were from basic requirements – records being legible, dated, timed and the persons role, records being incomplete, not meeting professional standards such as NMC through to changes in how technology is used such as ensuring RiO recording support practice and having use of 3G network for in patient staff providing support for clients receiving physical health inpatient care in other hospitals.
Action in response

- Audits of aspects of record keeping and action plans
- Laps top with 3G to support communication and real time recording in Rio when a patient has been transferred for acute physical care but still requires support on a shift by shift basis from the Trust.
- Rio group reviews recording mechanisms to support clinical practice.

6. Communication between staff – same service (9)
There have been some errors in recoding in this section as some of the communication issues should have been recorded in carer section (2) or care pathway (6).
Only 1 recommendation was in relation to same team communication – this was in relation to use of handovers.

7. Patient engagement & communication (3)
It is encouraging that there are few recommendations in relation to patient engagement and communication. There were 3 recommendations, two were in relation to checking contact details on discharge, one was ensuring communication method was clear and appropriate in terms of risk

Action in response

- A checklist has been developed to ensure contact details are correct

8. Carers/family – communication, liaison, assessment (18)
Although engagement with service users has not raised many recommendations, work with carers has produced a significant number.
Recommendations have arisen in relation to lack of recording next of kin information through to not providing information about services. There were also a number of recommendations around involving carers in information gathering at the earliest opportunity for both service users who are inpatients and community patients. A numbers of carers when discussing incidents with investigators reported their concerns not being recorded or minimised when checked with the service user. When something goes wrong services generally communicate with carers and families well but there were 2 recommendations in relation to this not being timely.

Action in response

- Serious incident investigators will wherever possible contact carers
- The fact find report prompts who has been in touch with families
- Discussion with RiO staff re recording next of kin
- CPA good practice reinforces contact with families
- Being Open is now a contractual duty

9. Medicine management (4)
One recommendation was in relation to community staff only leaving medication with the person to whom it is prescribed. Another three were in relation to the roles of the psychiatrist in medication reviews.

Action in response

- Medicine management guidance has been reinforced
- IHBT/CRS clients now see psychiatrist

10. Physical health care (mental health patients)(2)
Both recommendations were to consider the implementation of VTE NICE guidelines.

Action in response

- A considerable amount of work and liaison with NICE and national leads in relation to this as the guidelines are for acute trusts. The principles of the guidance have been implemented on all inpatient mental health wards. The guidance was already in place in full within physical health settings in the Trust.

11. Environment/equipment – security and safety, furniture, medical devices, hardware, ligatures, storage, etc (2)

To review signage at the Dales as “Oakdale” could be confused with Oakdale psychological therapy service which is not a trust service. The second recommendation was the storage of AED and oxygen in Newton Lodge

Action in response

- Datix forms to be filled re any confusion over signage.
- Review taken place re storage

12. Staff education, training & supervision (25)

There has been a significant increase in the number of recommendations in relation to staff education, training and supervision this year.
There have been recommendations about ensuring local inductions are reviewed and robust to prepare the team member. Clinical areas need to ensure staff are up to date and confident about falls, risk assessment, pressure area care, CPR/AED, safeguarding.
Recommendations to provide joint training opportunities with A&E staff and GPs on shared care cases.
Staff have raised concerns about the level of formal support being offered to them in line with the supporting staff following an incident, claim or complaint policy.
A recommendation to ensure NICE guidance is cascaded.

Action in response

- Specialist advisors have recommendations shared with them
- There has been a review of the training policy
- There have been a number of NICE guidance workshops
- Through appraisal training plan is highlighted

13. Policies and procedure in place but not adhered to (15)

4 polices are referred to within recommendations

- Supervision
- Supporting staff following a traumatic incident
- CPA
- Being open

Interestingly discharge and DNA are not listed specifically but a number of issues in relation to discharge have been raised.

Action in response

- Supporting staff was primarily raised in relation to a cluster of incidents within the same team around the same time. The management have put in place support for staff and a recent incident identified no issues.
- Being Open is now a contractual duty and the fact find report prompts services to contact families. When things go wrong the lead serious incident investigators also contact families wherever possible.

- Kirklees BDU have started some work with the CPA manager following them noticing a cluster of recommendations

14. Team/service systems, roles & management (27)

Again this is range of issues for example operational polices need reviewing/clarifying or developing in some cases. A protocol for managing differences of opinion in relation to urgency of referral needs drawing up. Out of hours support needs communicating.
Team manager absences – arrangements need to be clear

Action in response

- The response is individual to that team and shared in the BDU.

15. Organisational systems, management, policy, procedures (22)

Recommendations in this section can be wide reaching and require wider consideration/ exploration for example

- The roll out of Rio in Barnsley BDU mental health services
- Whether there could be consideration of a some beds for people requiring a longer stay in hospital.
- A Trust wide crisis care referral process
- Ensuring all CBT and psychology records are on RiO
- New policy requirements – re mobile phones, computers

Action in response

- RIO optimisation
- Trust wide acute services review – issues placed as part of the review
- Policy development
- Discussions with commissioners

16. Information governance - confidentiality breach, information management (1)

Consent to share being recorded on RiO

Action in response
A briefing was sent to staff

17. MHA, MCA & consent (3)

Two recommendations in relation to section 17 leave and the third one to developing guidance for detained patient who go out of area to receive treatment as an inpatient – this was not a practice issue but guidance could have helped provide clarity sooner

Action in response

- Guidance is being developed to support staff

18. Other(4)

The four recommendations were in relation to:-
Reviewing action plans from previous incidents in crisis services, ensuring child protection responsibilities are in care plans, ensuring information about domestic abuse is available on wards The last one was in relation to Rio optimisation to review recording of care plan evaluation.

Action in response

- Domestic abuse information available on wards

7. Patient safety Support team / Incident management developments and progress in 2012/13

a) Introduction

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

b) Strategy

Patient Safety, incident reporting and learning lessons have been high on the political agenda this year. There has been the publication of a number of key investigations including Winterbourne and the Francis report into Mid Staffordshire Foundation Trust. The executive management team had already responded to a review the incident management and governance. This resulted in significant investment in practice governance coaches, lead serious incident investigators and sessions for senior medical staff to support investigations.

c) Flawless execution

i. Datix and Datix-web developments

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

In addition the Datix system has been further developed Trust-wide

- All team managers have access to Datix-web to run real time reports
- All Specialist advisors have been trained in the use of Datix-web and now receive automated email notifications of incidents related to their speciality as they are reported, which enables them to support incidents as they occur, review incidents and produce reports
- The Datix-web system now allows documents to be attached to the incident record, such as incident review reports, actions taken, communications
- The guidance section on the intranet to support managers and staff in using Datix-web has been developed.
- Additional fields have been added to support analysis of clinical practice.
- The Serious incident investigation section has been developed to include actions, and all recommendations from investigation reports are now being coded to enable more analysis of learning
- Work has been undertaken to produce a flexible approach to enable capture of AQP (Any qualified provider contracts as they are set up)
- Have delivered a work programme following dialogue with users to develop use of Datix:
    - Develop codes for non mental health services
    - Work with specialist advisors
- Work to provide a solution from the Datix system to be able to report to tutors when student staff or staff in training are involved in an incident. This covers all students and this enables support for the students and liaison with Universities about incidents.

ii. Analysis and learning – all incident severity grades

- Incident management reports and data have been provided regularly to Trust management groups which include information about incidents
    - Weekly summary of amber and red incidents and position of investigations
    - Monthly information into performance dashboard
    - Quarterly incident management report to CCCS committee
    - Quarterly serious incident report to board.
    - Many CQUIN targets are supported by information from Datix system.
- The Trust has continued to contribute to national learning by liaising with NPSA (key functions transferred to NHS Commissioning Board Special Health Authority) to ensure transfer of Trust incident information to the NRLS.
- CQC – the care quality commission receives a monthly report on abuse incidents as defined by NPSA.
- The Patient Safety Support Team continued to support and monitor the SI process, particularly through the provision of information to the Incident Review sub-committee (IRSC) of the Clinical Governance and Clinical Safety Committee
- Continue the analysis of recommendations from serious incident investigation reports, by coding each recommendation. The analysis can be by type or within clinical settings e.g. all recommendations linked to an inpatient serious incident.
- Two members of medical staff have undertaken a review that examine the themes and trends arising from a cohort of suicides within the Trust.

iii. Policy review and update

Policies have been brought together that covered Barnsley and SWYPFT and updated to meet national guidance. These policies meet the requirements of NHS litigation authority risk management standards and were complimented as clear and good practice by a leading national expert who reviewed them.

iv. Serious Incident lead investigators and supporting medical investigators

Following a successful business case last year, in January 2013 four lead investigators were appointed. In addition six senior members of medical staff have one session per week to support investigations. Although only in post for less than 3 months the impact of these posts is already being positively recognised.

v. Training

The patient safety support team continue to provide sessions at the Trust induction and medical trainee inductions. The team have undertaken numerous training sessions on improving the quality of reporting information and drop in sessions to improve skills. Each BDU has been asked to review and strengthen where necessary the governance procedures for managing and learning from incidents.

d) Structure

This year has seen the review of the incident review subcommittee, the focus of this meeting is to receive assurance and ensure the performance of incident management is satisfactory. This group is chaired by the Director of Nursing, governance and patient safety.

A clinical reference group has been set up to focus on the outcomes of incident reporting and investigation with the focus on learning and implications of serious incident management. This group is chaired by the associate medical director for patient safety.

e) Culture

The patient safety support team are focussed and constantly examining ways of effectively supporting the Trust to meet regulatory and best practice in terms of incident management. The culture within the team is to look for creative and innovative ways of delivering this work (see innovation). The cultural shift that needs to take place is the move from process which is now robust towards sharing the learning in a manner that is helpful to services.

f) Innovation

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

The team have looked at innovative solutions to respond to Deanery and University requirements to ensure sharing of information of incidents involving students and trainees.

g) Partnerships

i. Datix-web Safety Alerts and Bulletins (SABs) module

Roll-out of the Datix-web SABs module across in Barnsley BDU has been completed by the team. This means are all services are covered by the module.

ii. Modules on Datix

The patient safety Team continue to support the technical expertise for other modules on Datix that the Trust utilise

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

iii. NHS Litigation Authority

The team coordinated the level 1 assessment against the risk management standards along with colleagues from compliance that resulted in achievement of the standards in November 2012.

iv. Working with the BDUs

Each BDU and corporate service has a senior link person from the patient safety support team, this person is the first point of contact to discuss / request work from the team. The link person will also deal with reporting queries that arise from incidents within the BDU.

v. Audit and service evaluations

The investigators provide the data for some cases in relation to the unexpected deaths audit.
The PSST support a number of audits and service evaluations throughout the year by providing more detailed analysis of incidents.

vi. External partnerships

SHA and PCTs in terms of reporting and performance monitoring of incidents.

h) Leadership

Leadership of patient safety support team and incident management has been delegated day to day to the Assistant Director of Practice effectiveness since August 2011. This has involved bringing the support services together following the acquisition of Barnsley Care Services in terms of both policy and practice across the Trust. There has been the development of the business case for the establishment of lead serious incident investigator team and the recruitment.
Ensure improvement in terms of performance management of serious incident reports for Calderdale, Kirklees and Wakefield, the process in Barnsley was robust.

i) Talent Management

The team have been supported to develop both within the team by being given shadow and learning opportunities to develop. Team members have lead the NHS litigation process which also exposes their talents elsewhere – this has resulted in one member of the team undertaking a secondment at a higher grade in another team.
Team members have been encouraged to consider the Trust talent management programme and several have applied for consideration.

8. Key actions and areas for development in 2013/14

2013/14 will be another challenging year for the team. The impact of the publication of the Francis report will remain high on the agenda.

The team has developed a detailed work plan for the year
This year will focus on 3 areas:-

- Consolidation and maintenance of the work started/completed in 2012/3.
- Review of team structure
- Development / innovation work
    - Consideration of the Quality Account action to be able to produce a report of all incidents of death and severe harm from Datix that matches the data produced via background mapping for NPSA. This work will be based on the decision of the EMT once received
    - To examine the use of the performance dashboard module available from Datix and consider the use in the Trust. If considered useful to develop a business case for the module, implementation and maintenance of the module.
    - To develop video user guides to supplement written user guides for staff
    - To work with BDU and Quality academy to improve and develop learning through providing training, supporting workshops and other techniques.
    - To examine the feasibility of adding the management fact find straight onto Datix web as additional fields
- Work with Clinical support units to meet performance requirements from CCGs and LAT. This could be extremely challenging as from 1st June 2013 there is now an expectation that investigations will be completed in 45 days and not 60. The Trust is challenging this at the moment but if required then this will have an impact on the quality and / or scope of investigations. The CSU also require evidence of implementation of action plans e.g. if we change a policy we have to send it with the finished action plan. This will tighten governance but involve an added bureaucracy.

Analysis of Barnsley Serious Incidents April 2012 to March 2013

Chart B1 shows SIs by quarter April 2010 to March 2013. Barnsley Business Delivery Unit reported 8 serious incidents over this financial year. This was a significant reduction from the previous year which was 17.

Chart B1 Barnsley Serious Incidents 2010/11 – 2012/13 by quarter

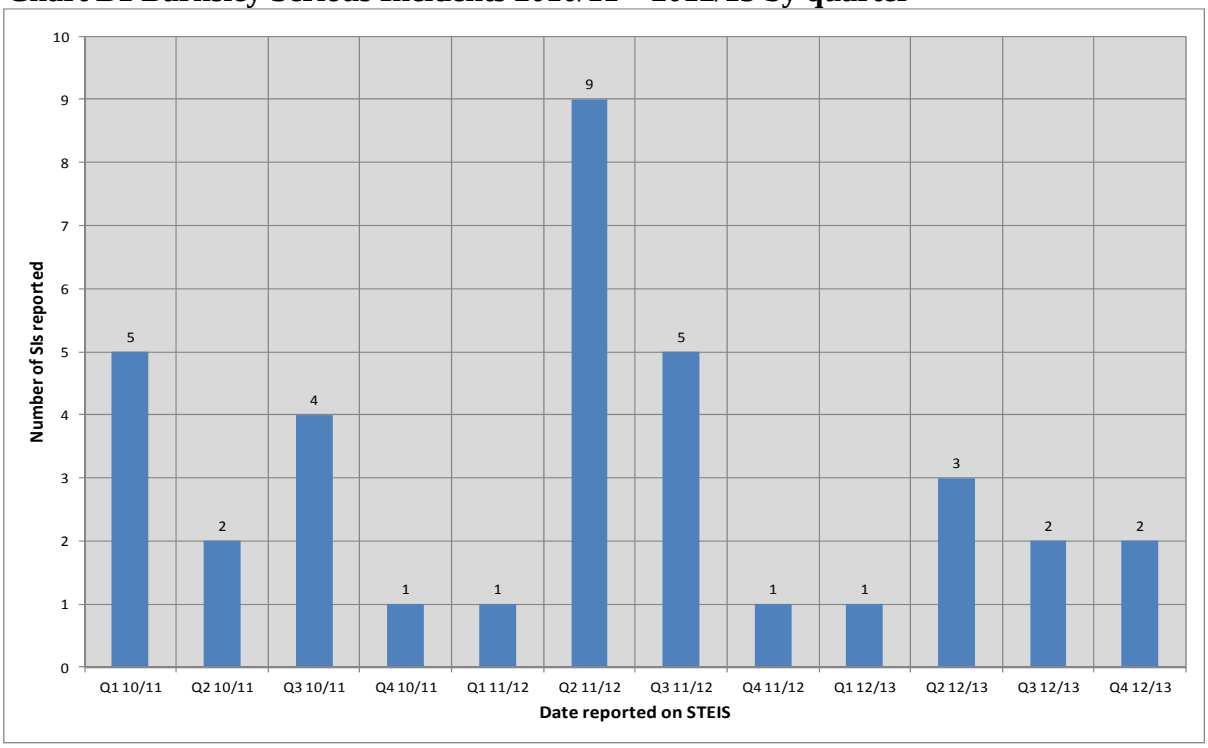
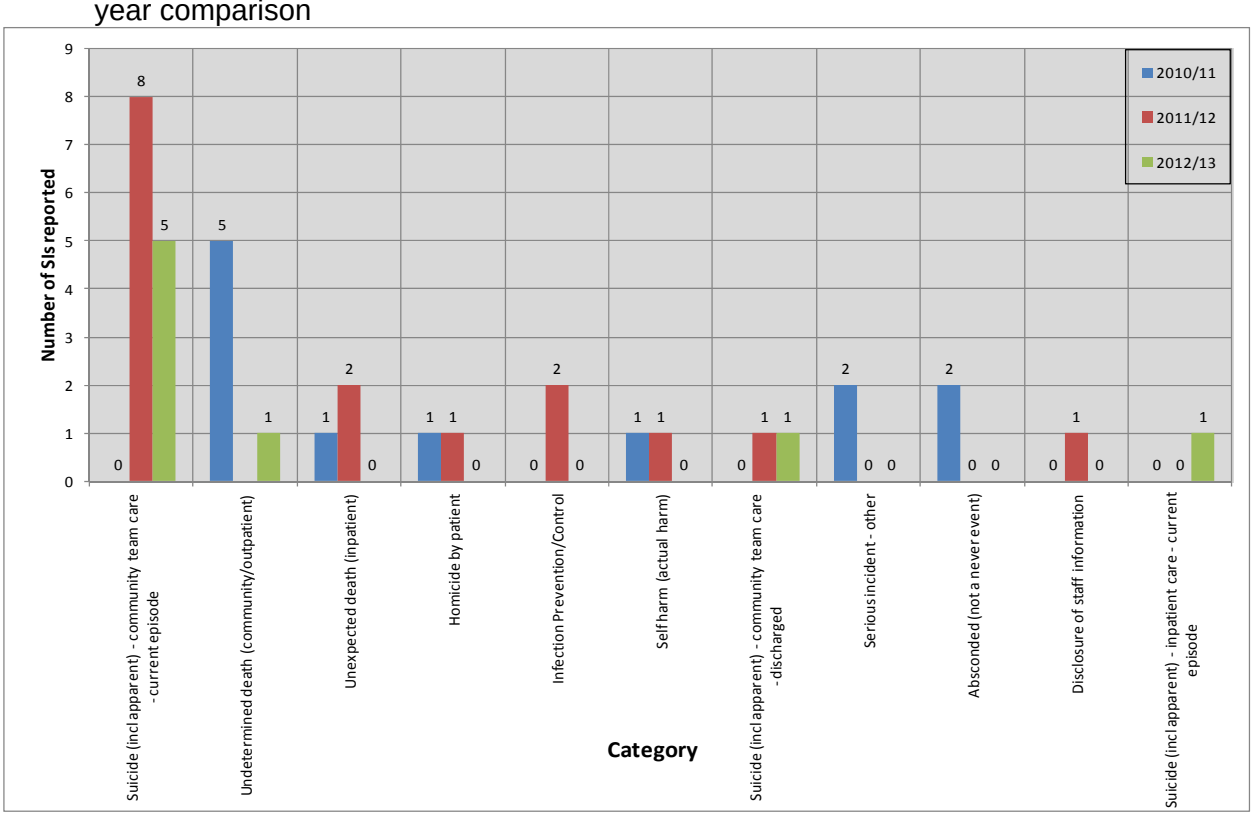


Chart B2 Barnsley Serious Incidents 2010/11 – 2012/13 by category showing financial year comparison



The National Confidential Inquiry figures July 2012 indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2000 to 2010 there are approximately 10.04 suicides per 100,000 general population each year. (range 8.6-11.2)
- On average during 2000-2010 patient suicides accounted for 27% of the general population suicide figures (range 2.4-3)

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

2012/13 - Incidence of suicide by Trust BDU populations and NCI suicides rates

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)
Barnsley	235,976	20-26/7	5-7

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

Suspected Suicides reported on STEIS each quarter 2012/13

District	Qu1	Qu2	Qu3	Qu4	Total
Barnsley	1	3	1	2	**7**

Chart B3 Barnsley Serious Incidents 2012/13 by unit

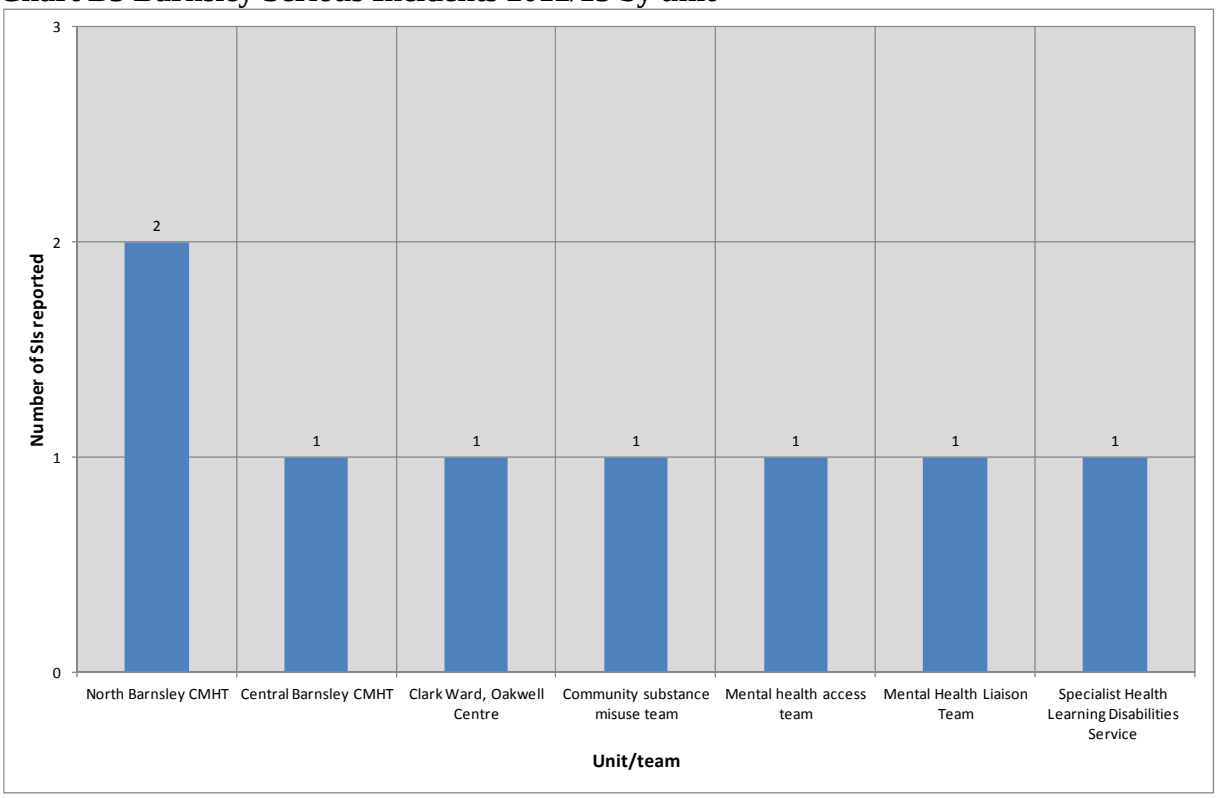


Chart B3 and B4 shows that the incidents for 2011/12 and 2012/13 were spread across a range of teams. No incidents were reported by community healthcare or IAPT in 2012/13 services. Of note is the reduction in IAPT serious incidents from 2011/12.

Chart B4 Barnsley Serious Incidents 2011/12 by unit

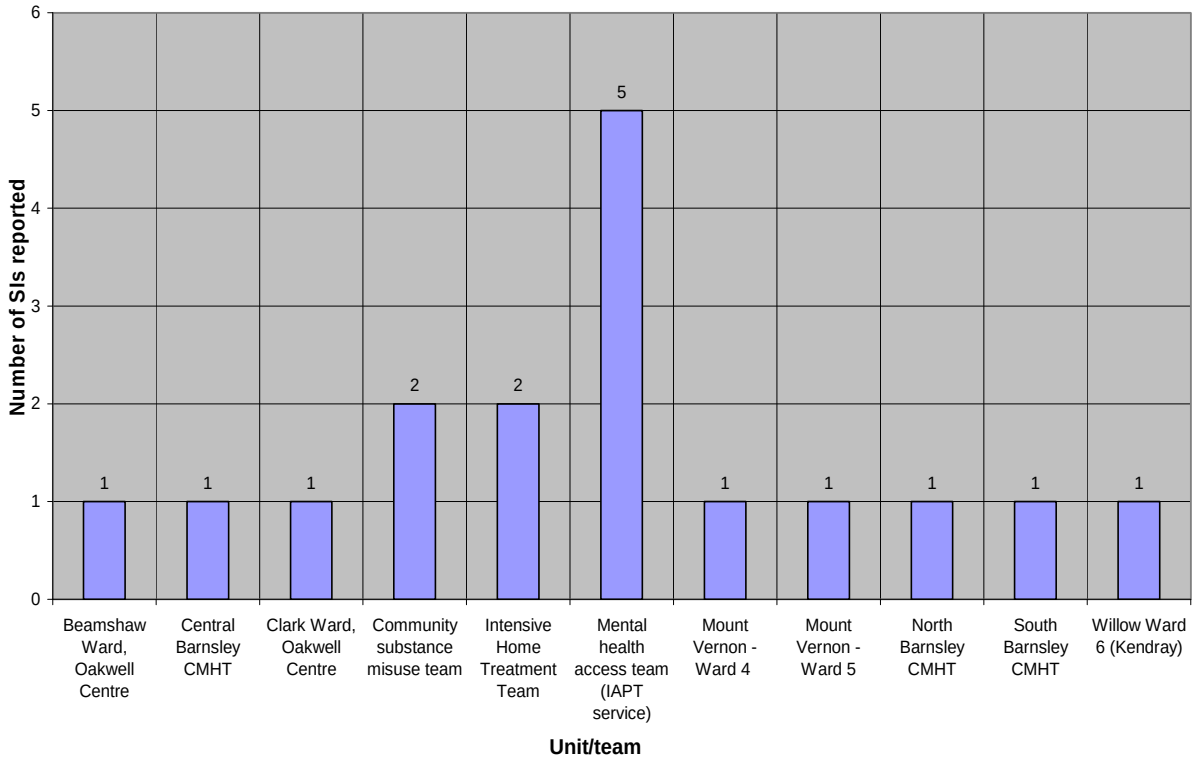


Chart B5 2012/13 recommendations for Barnsley SIs sent to Commissioners – by type

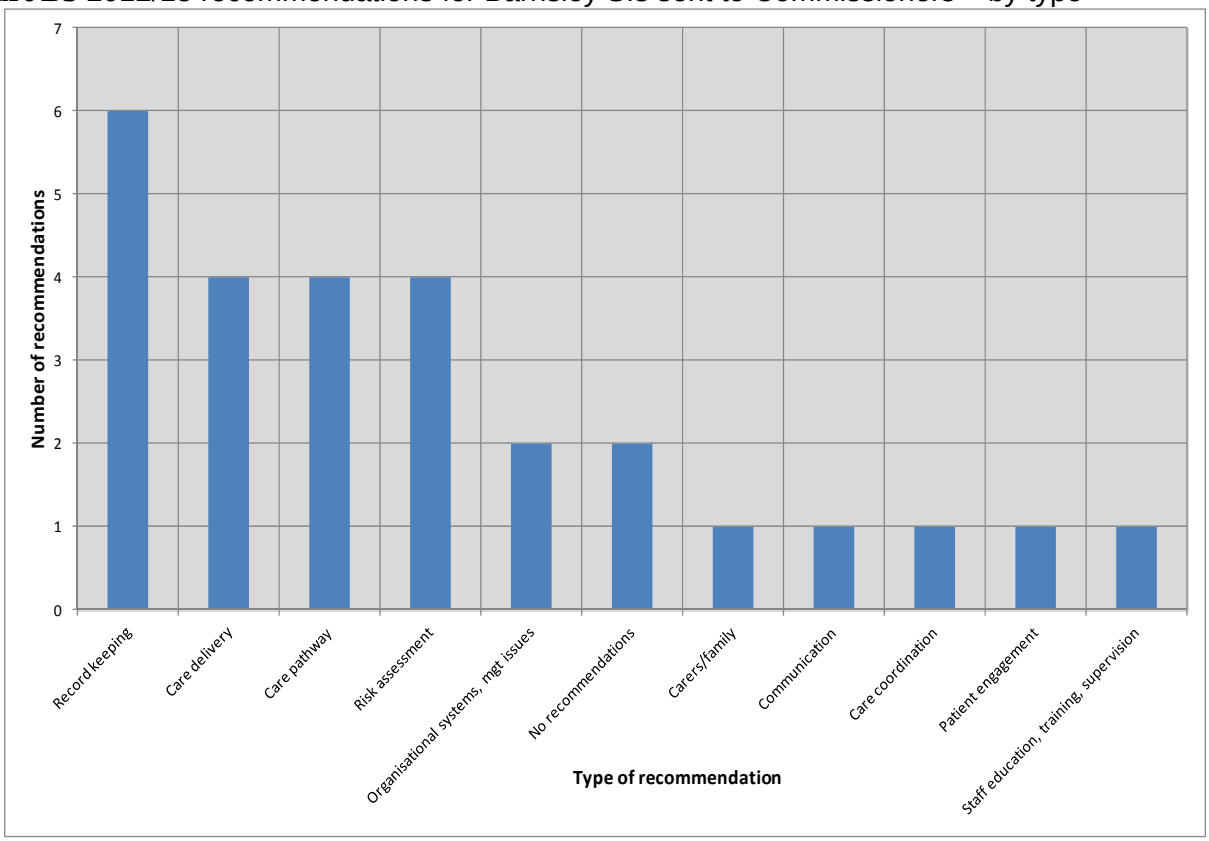


Chart B6: 2011/12 recommendations for Barnsley SIs sent to Commissioners – by type

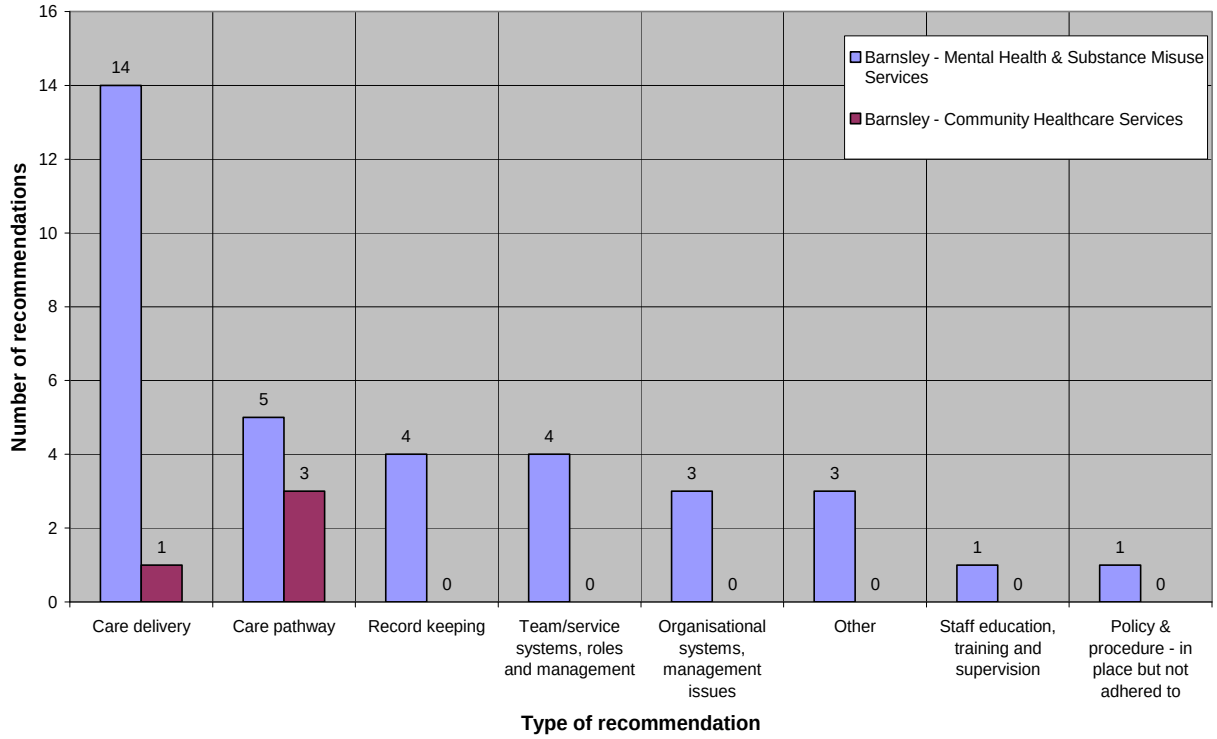


Chart B7: 2011/12 recommendations for Barnsley SIs sent to the PCT by service

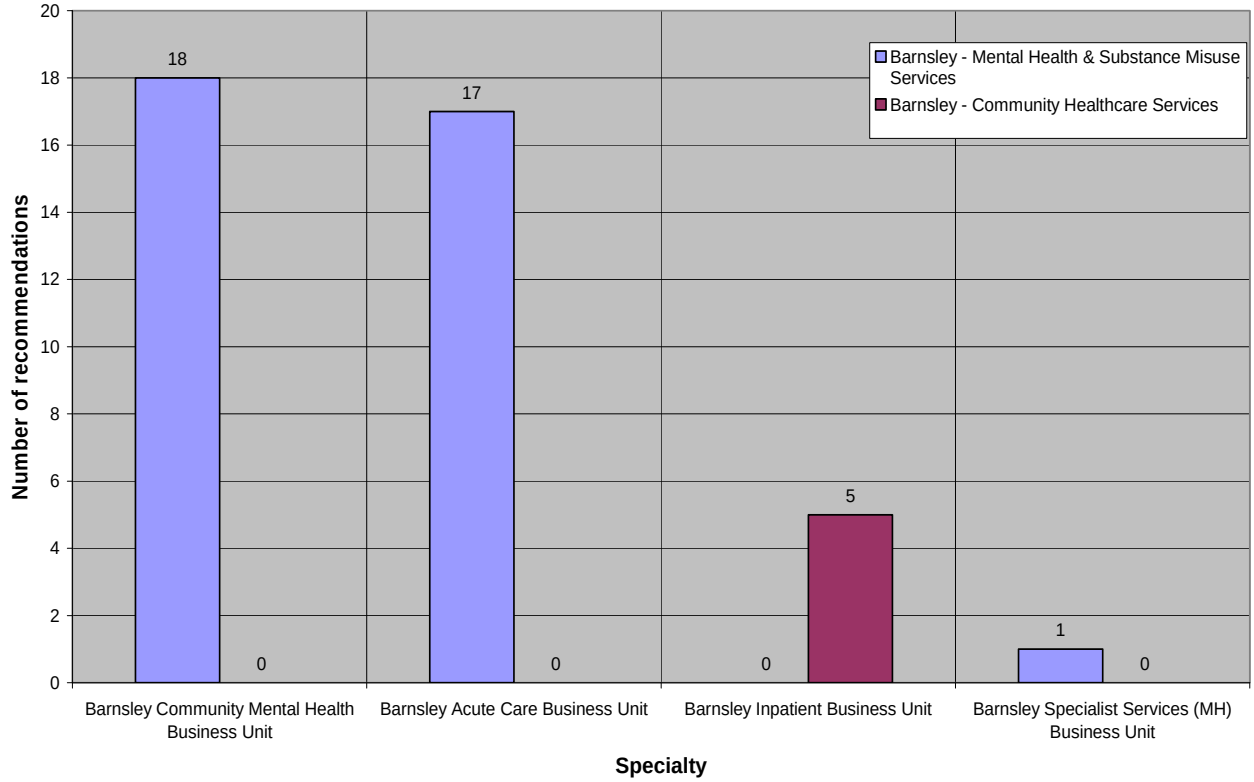
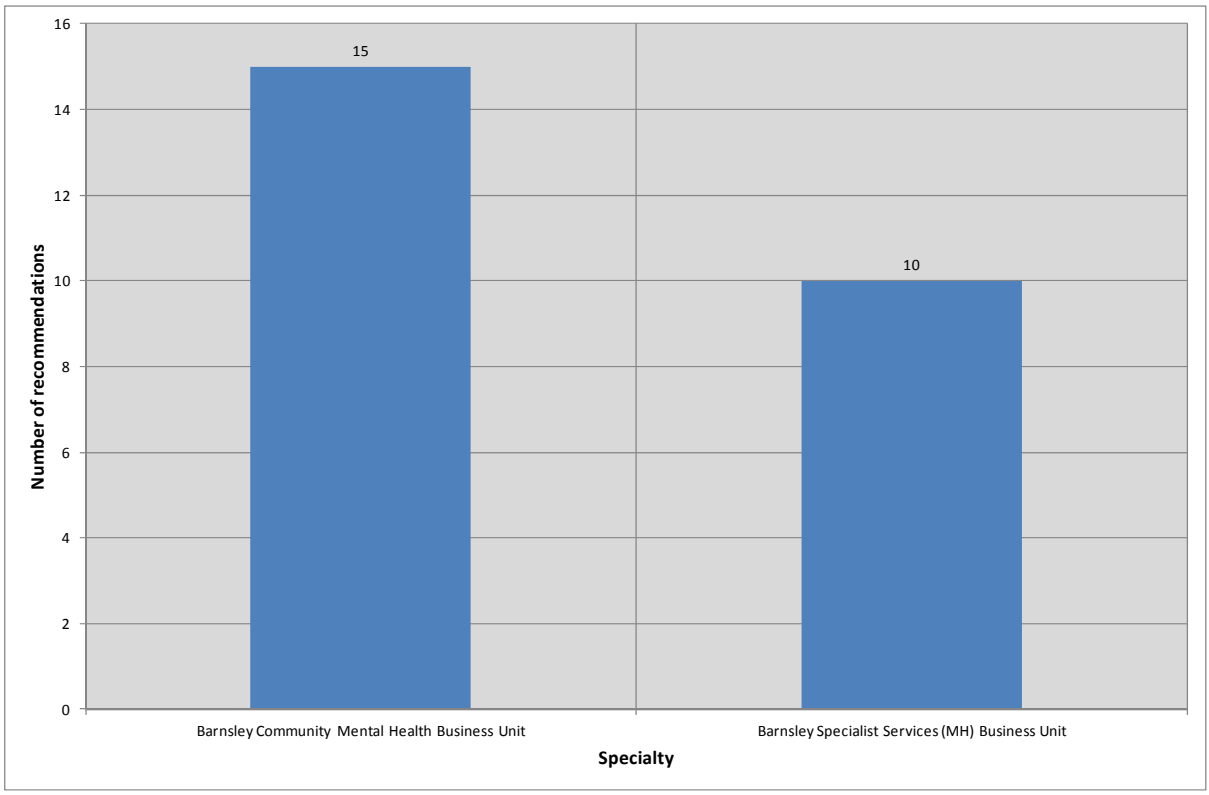


Chart B8: 2012/13 Barnsley BDU SI recommendations sent to PCT - by service



Analysis of Calderdale Serious Incidents April 2012 to March 2013

Chart C1 shows the number of SIs reported by Calderdale services quarter from April 2010 to March 2013. Calderdale reported 8 Serious Incidents in 2012/13. This is an increase from previous years. C1 also shows a variable pattern. The numbers are in fact small.

Chart C1 Calderdale Serious incident 2010/11-2012/13 by quarter

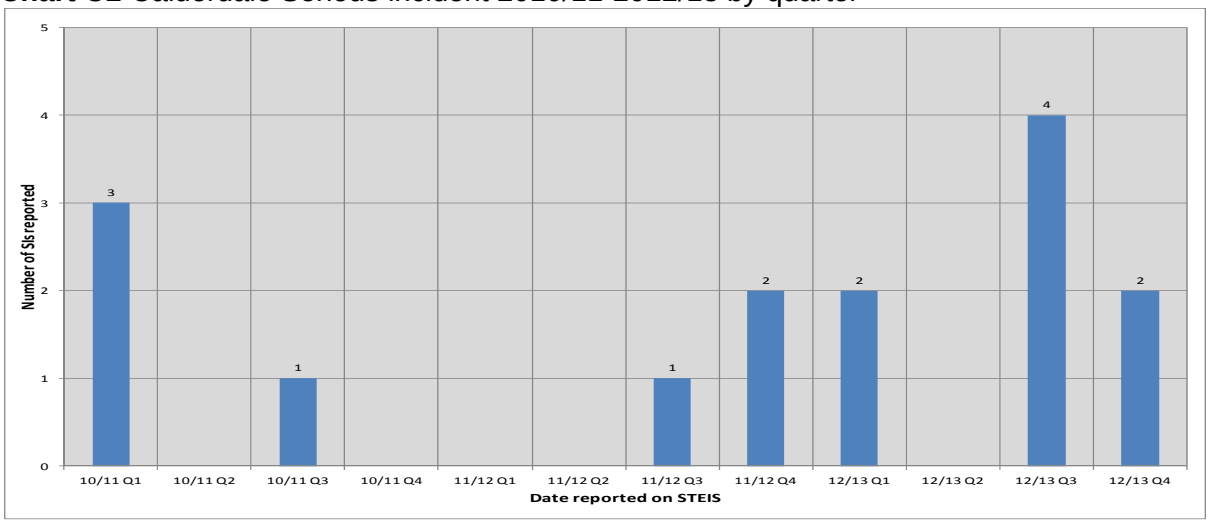


Chart C2 Calderdale Serious Incidents 2010/11 – 2012/13 by category

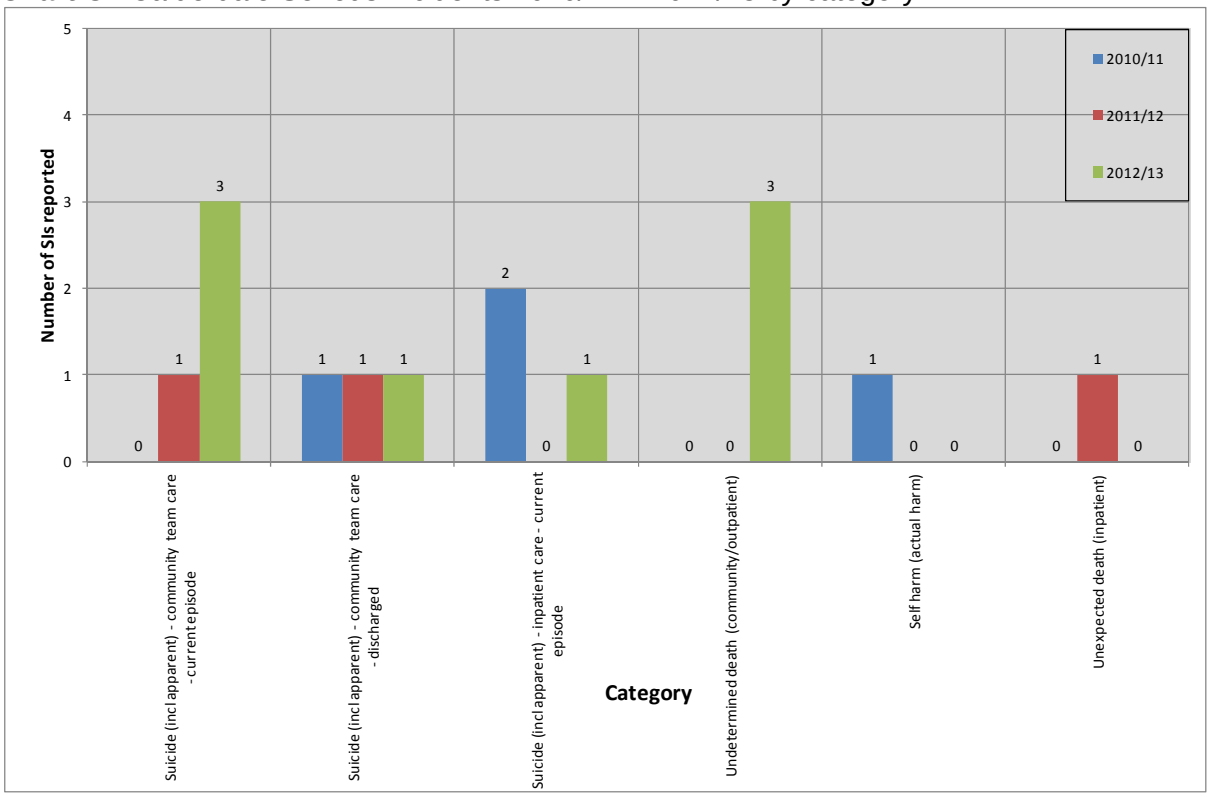


Chart C2 shows the comparison by type. 2012/13 suspected suicide was the highest category (5 in total) but numbers are small and not an outlier in terms of NCI data.

The National Confidential Inquiry figures July 2012 indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2000 to 2010 there are approximately 10.04 suicides per 100,000 general population each year. (range 8.6-11.2)
- On average during 2000-2010 patient suicides accounted for 27% of the general population suicide figures (range 2.4-3)

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

2012/13 - Incidence of suicide by Trust BDU populations and NCI suicides rates

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)
Calderdale	202,841	17-22/23	4-6

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

Suspected Suicides reported on STEIS each quarter 2012/13

District	Qu1	Qu2	Qu3	Qu4	Total
Calderdale	1	0	3	1	**5**

Chart C3 Calderdale Incidents 2012/13 by unit

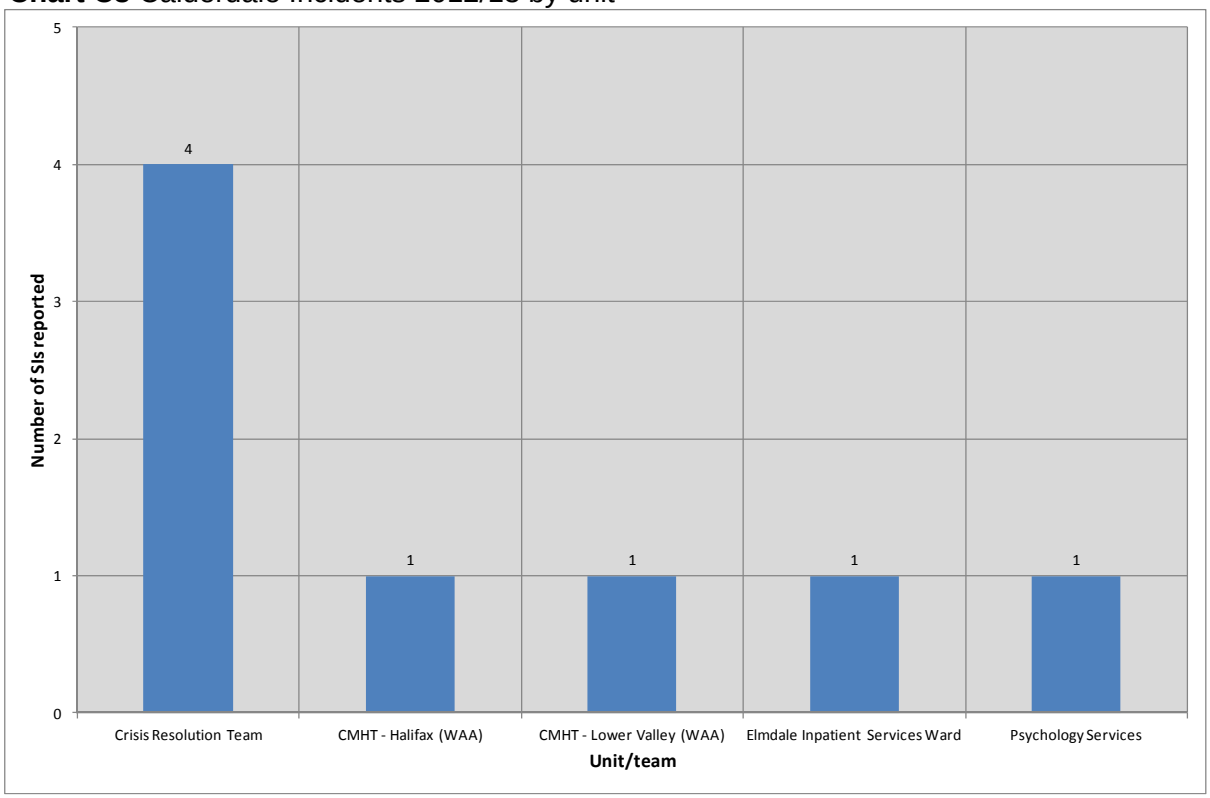


Chart C3 shows an increase in incidents in crisis resolution service, there was more in this year than the previous two years combined. The service undertook further analysis of these incidents. **Chart C4** (below) shows the 15 SIs reported April 2009 to March 2012 by team or unit. 12 cases were in working aged adult services and 3 in older people's services. Of these three, two occurred in inpatient services. There is no indication of a cluster in any one team or service.

Chart C4: Calderdale Serious Incidents 2009/10 to 2011/12 by unit

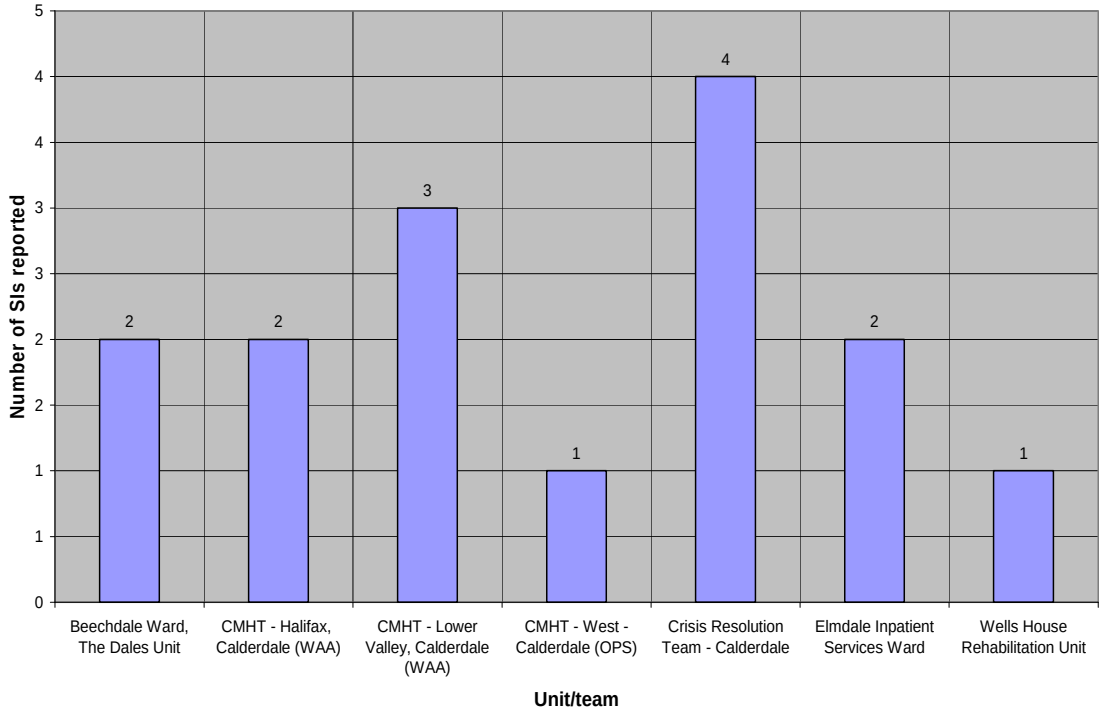


Chart C5 2012/13 recommendations for Calderdale SIs sent to Commissioner by type

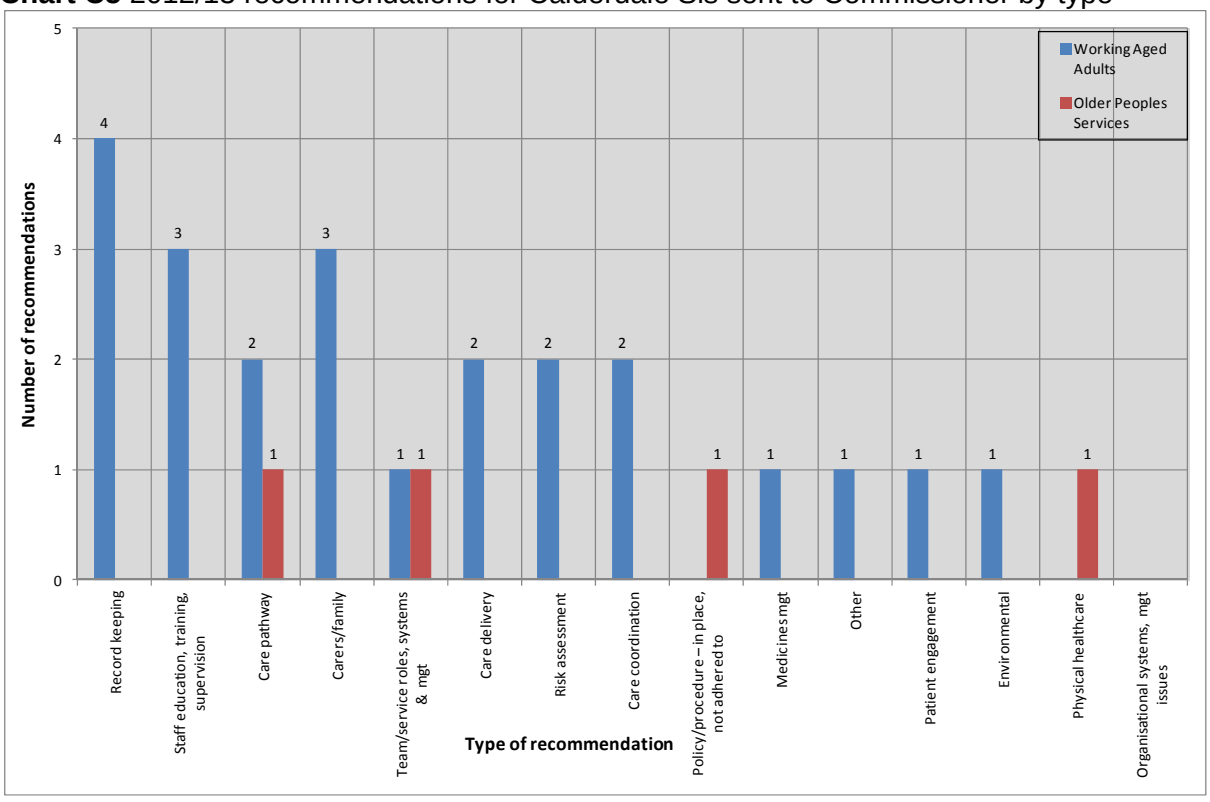


Chart C6: 2011/12 Calderdale SI recommendations sent to the PCT - by type

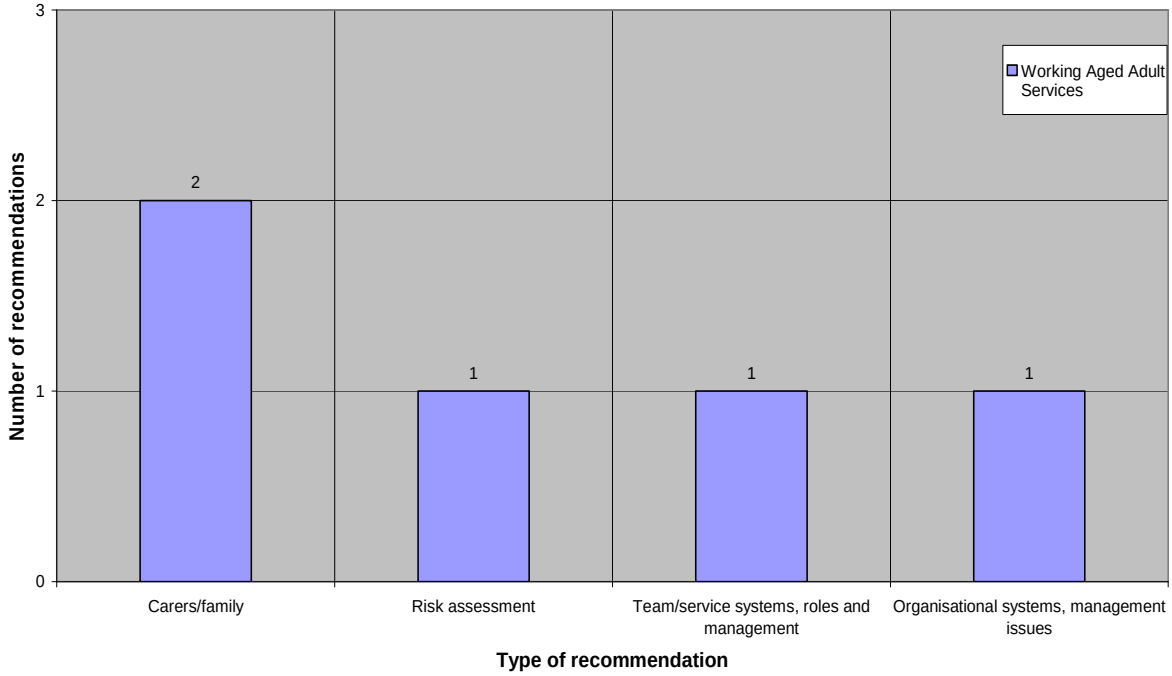
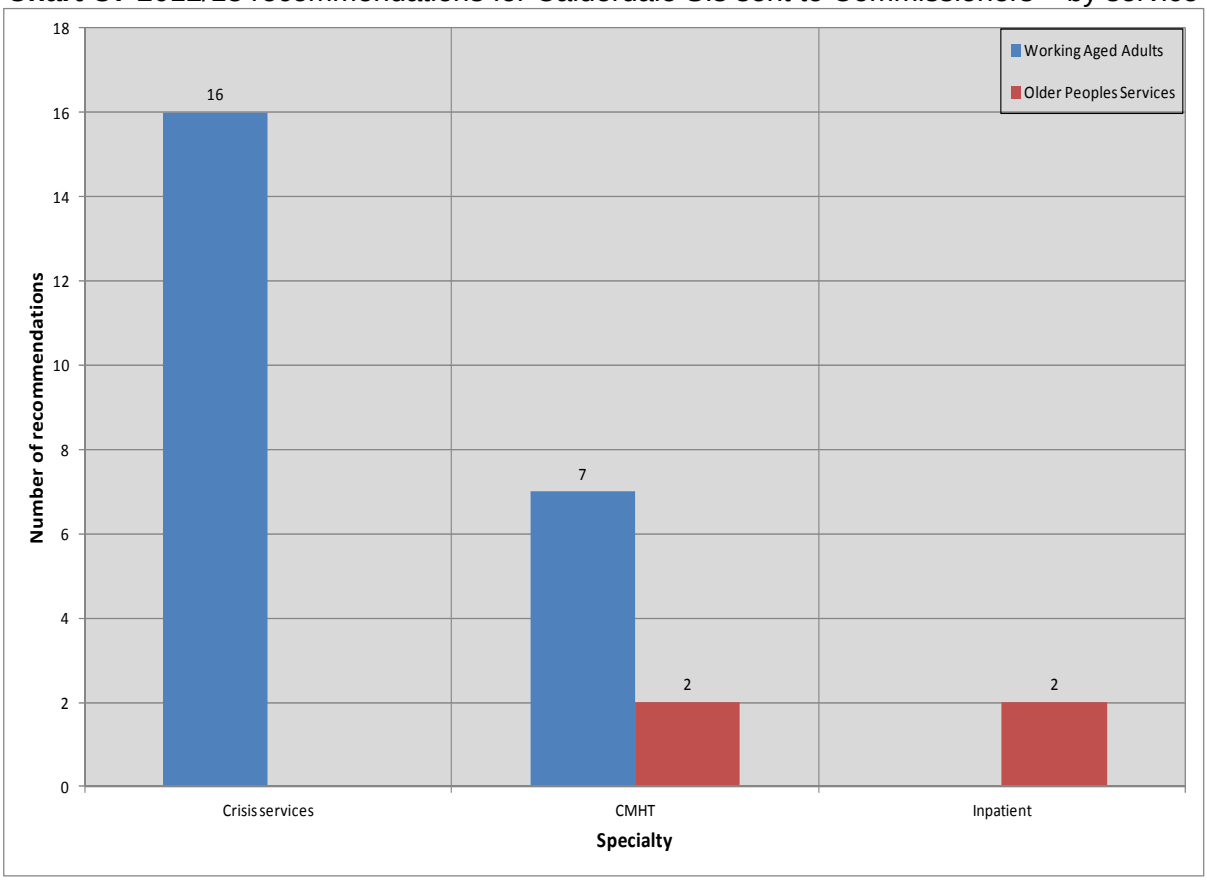


Chart C7 2012/13 recommendations for Calderdale SIs sent to Commissioners – by service



Analysis of Kirklees Serious Incidents April 2012 to March 2013

Chart K1 shows the number of Kirklees Serious Incidents (SI) reported by SWYPFT by year from April 20010 to March 2012. Kirklees reported 13 serious incidents during 2012/13

Chart K1 Kirklees Serious Incidents 2010/11 – 2012/13 by quarter

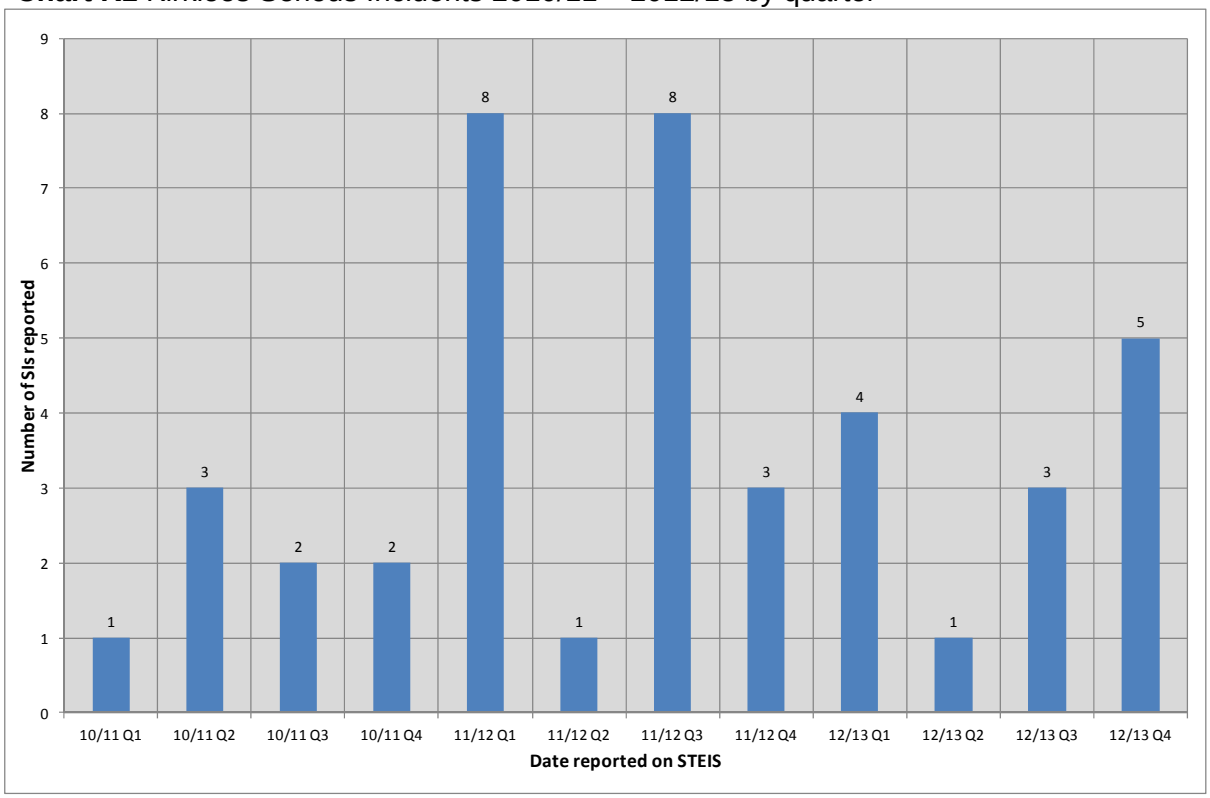
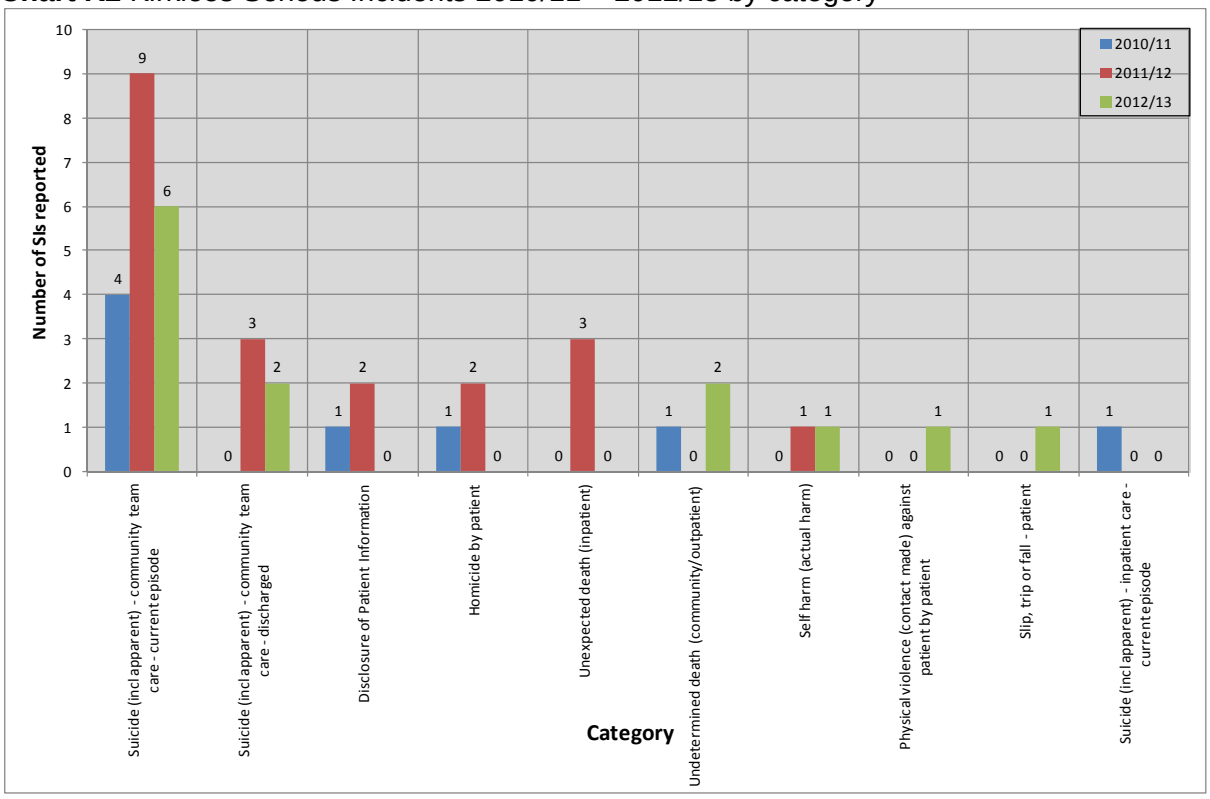


Chart K2 Kirklees Serious Incidents 2010/11 – 2012/13 by category



The National Confidential Inquiry figures July 2012 indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2000 to 2010 there are approximately 10.04 suicides per 100,000 general population each year. (range 8.6-11.2)
- On average during 2000-2010 patient suicides accounted for 27% of the general population suicide figures (range 2.4-3)

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

2012/13 - Incidence of suicide by Trust BDU populations and NCI suicides rates

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)
Kirklees	400,920	34-44/45	9-12

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

Suspected Suicides reported on STEIS each quarter 2012/13

District	Qu1	Qu2	Qu3	Qu4	Total
Kirklees	2	1	2	3	**8**

Chart K3 Kirklees Serious Incidents 2012/13 by unit

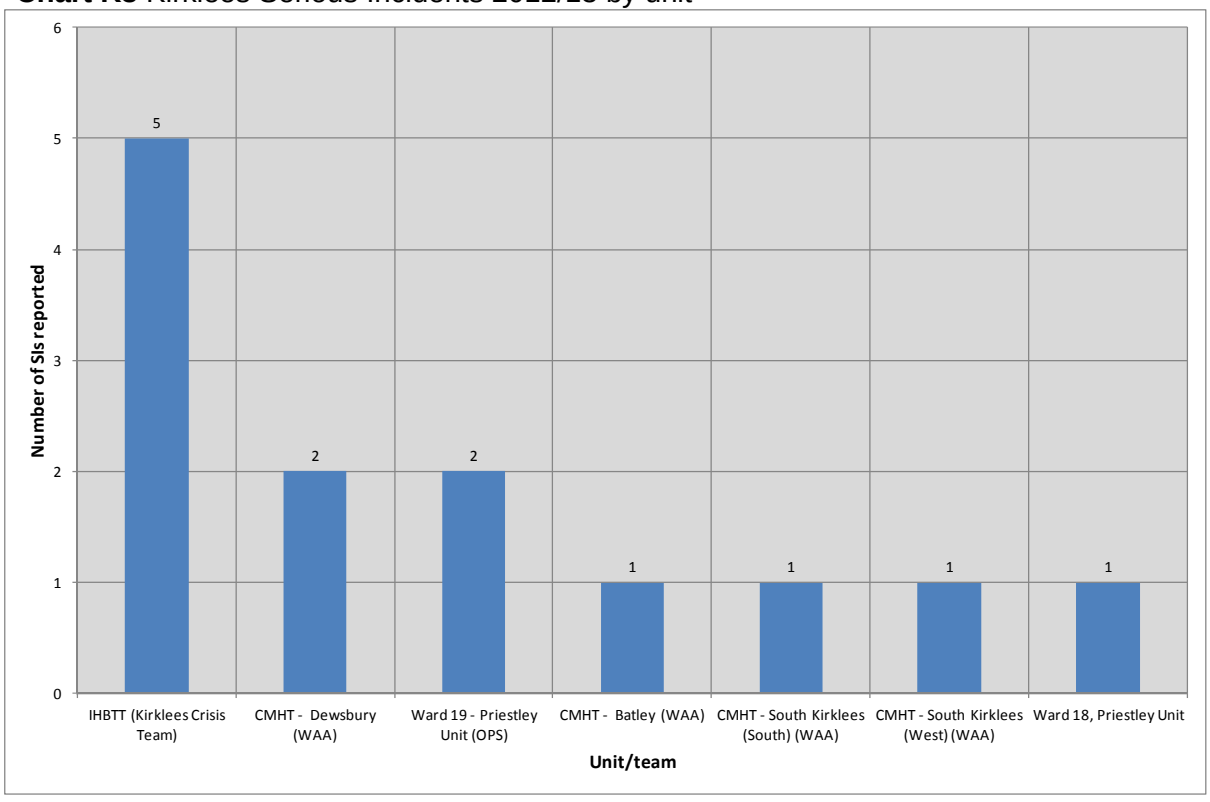


Chart K4: Kirklees Serious Incidents 2009/10 to 2011/12 by unit

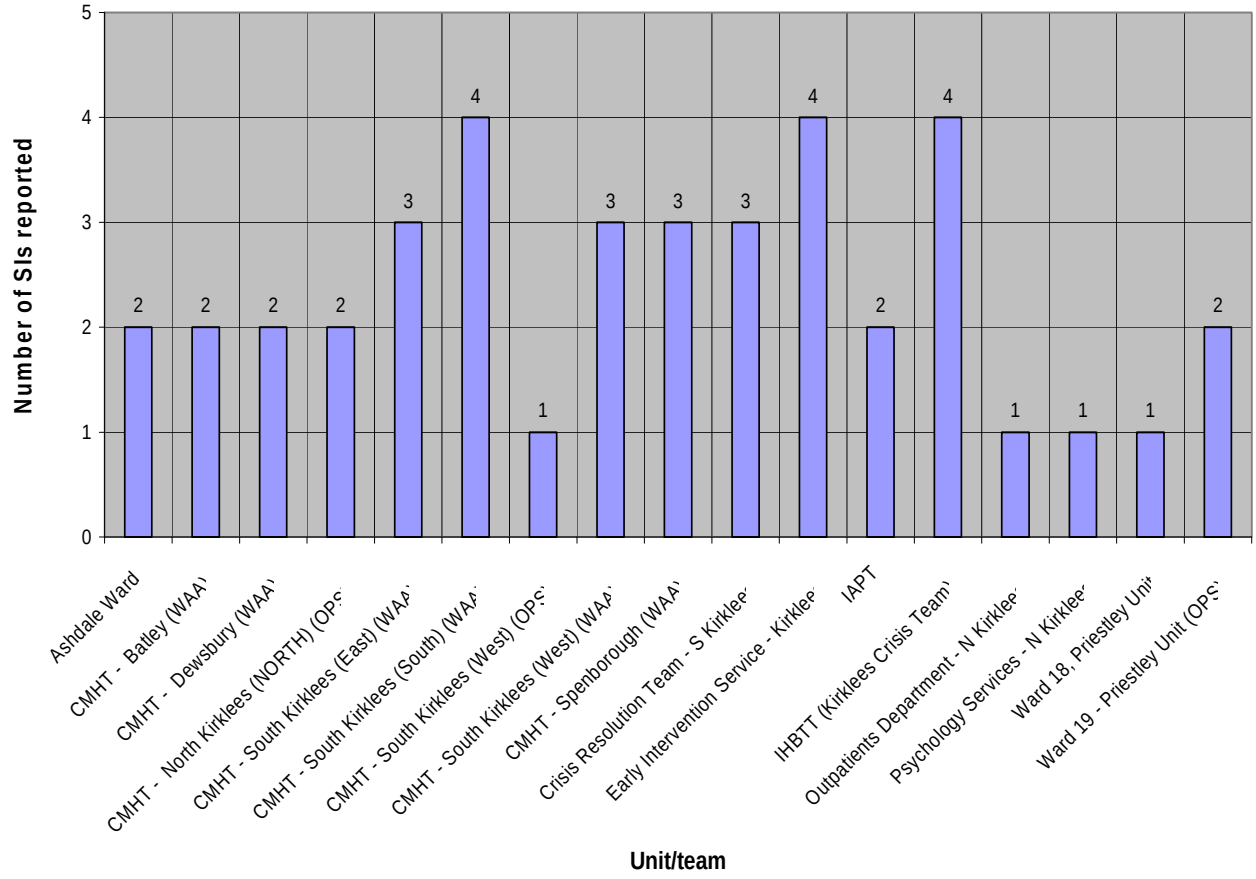


Chart K5 2012/13 recommendations for Kirklees SIs sent to Commissioners – by type

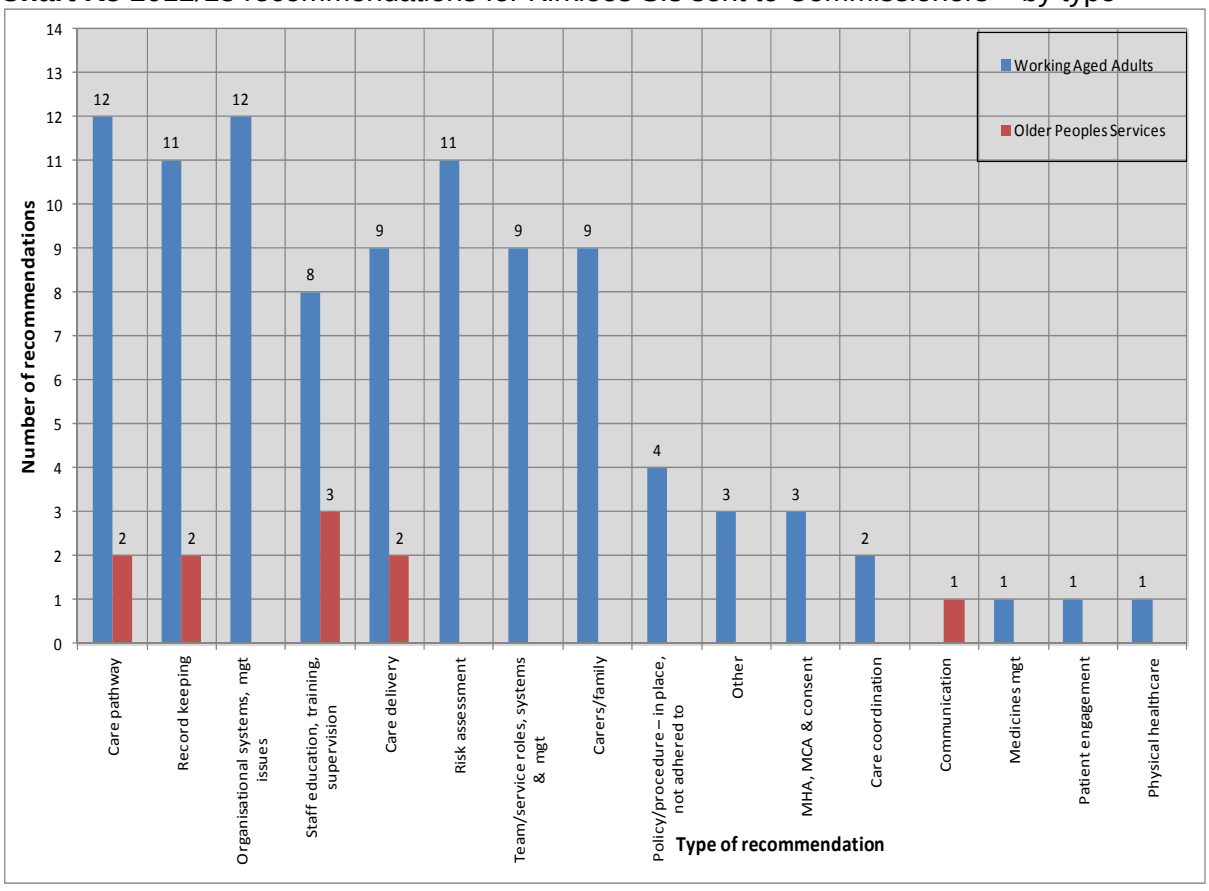


Chart K6: 2011/12 recommendations Kirklees SIs sent to PCT - by recommendation type

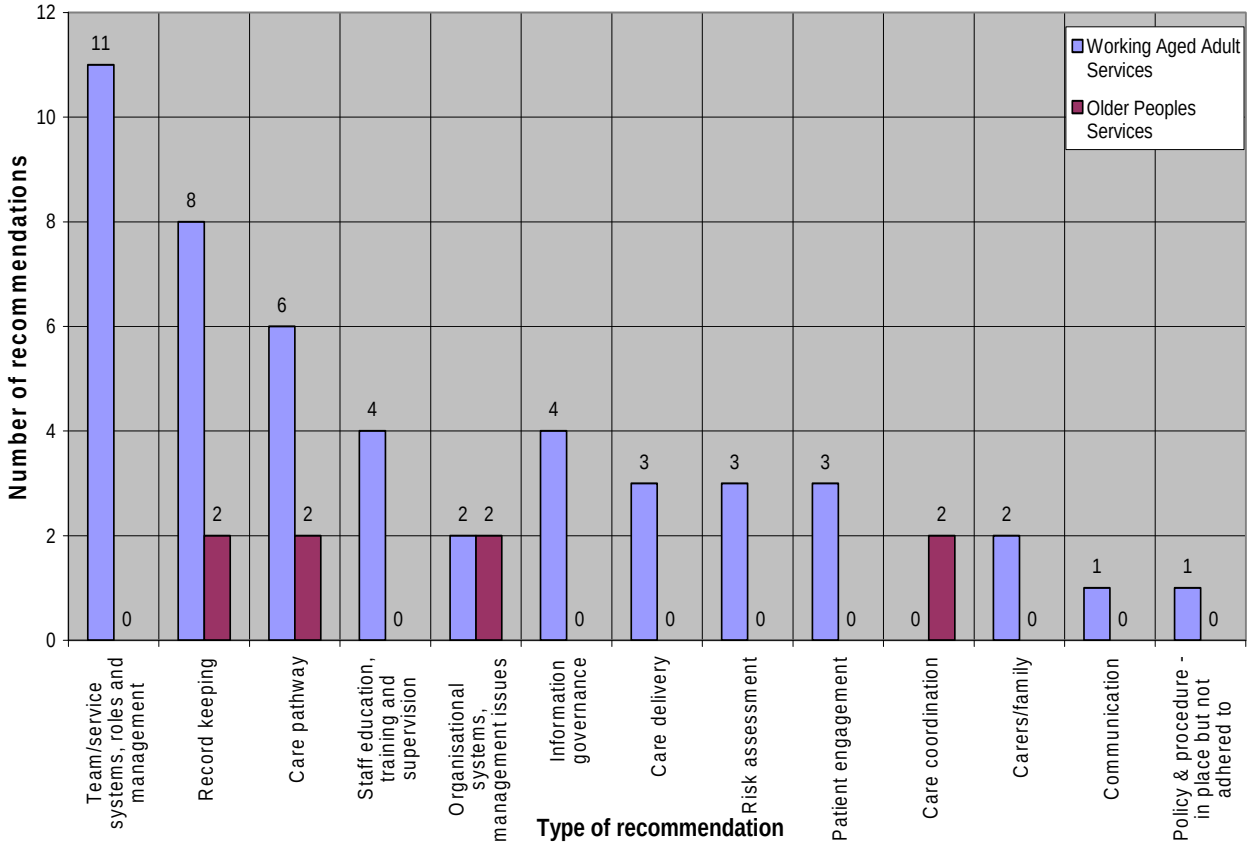


Chart K7 2012/13 recommendations for Kirklees SIs sent to Commissioners – by service

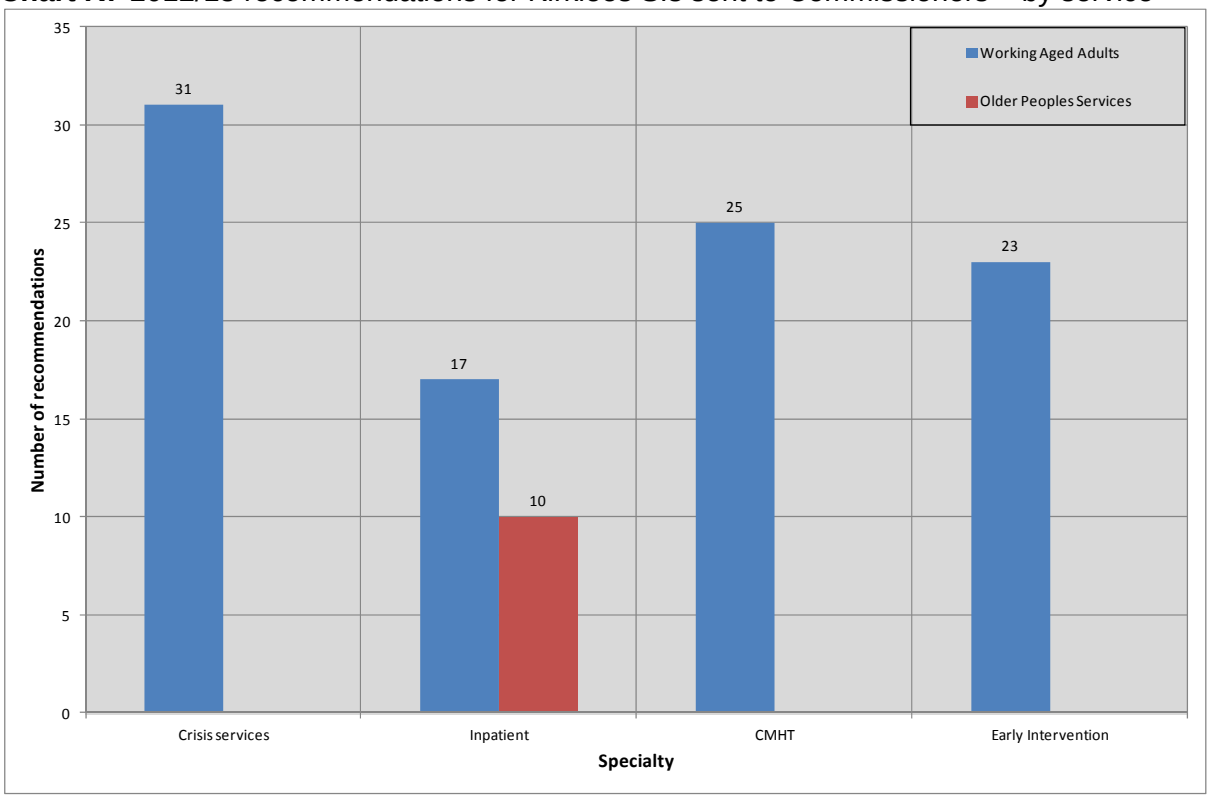
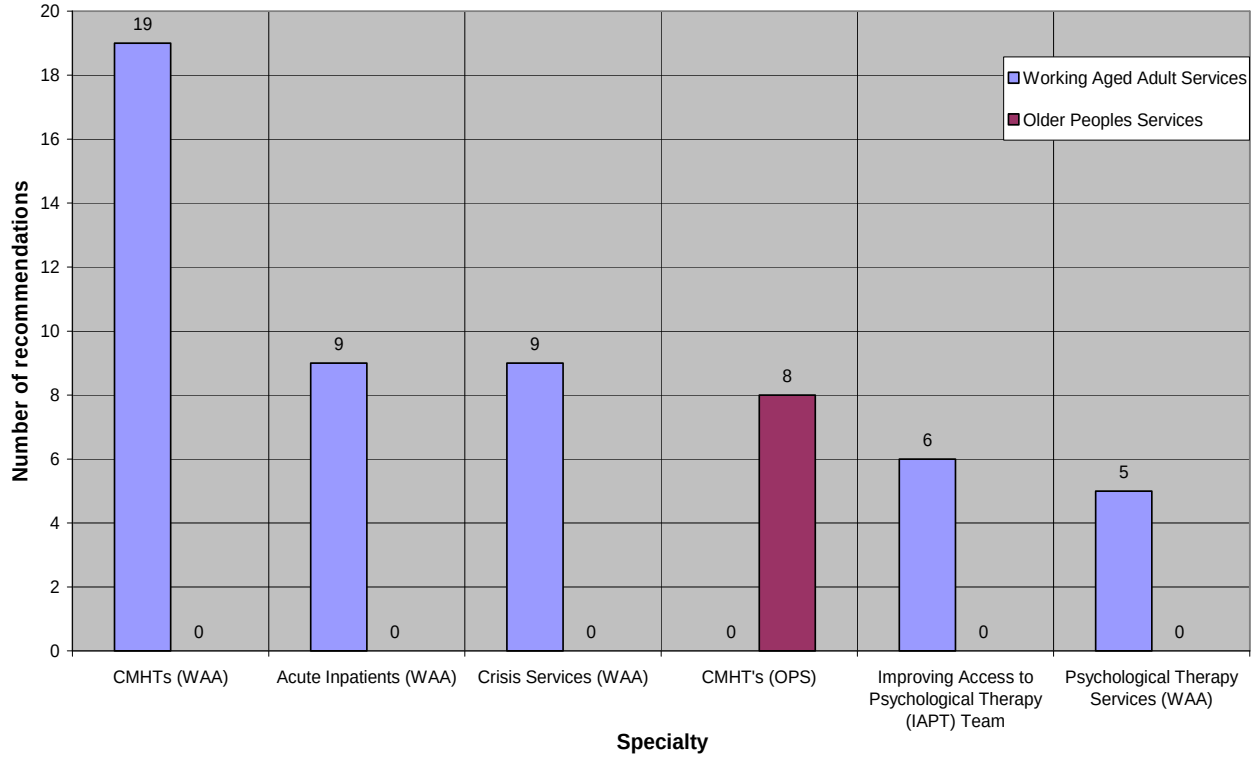


Chart K8: 2011/12 recommendations from Kirklees SI sent to PCT by service/specialty.



Analysis of Wakefield Serious Incidents April 2012 to March 2013

Chart W1 shows the number of Wakefield SIs reported by SWYPFT by year from April 20010 to March 2013. Wakefield reported 14 serious incidents

Chart W1 Wakefield Serious Incidents by financial quarter 20010/11 to 2012/13

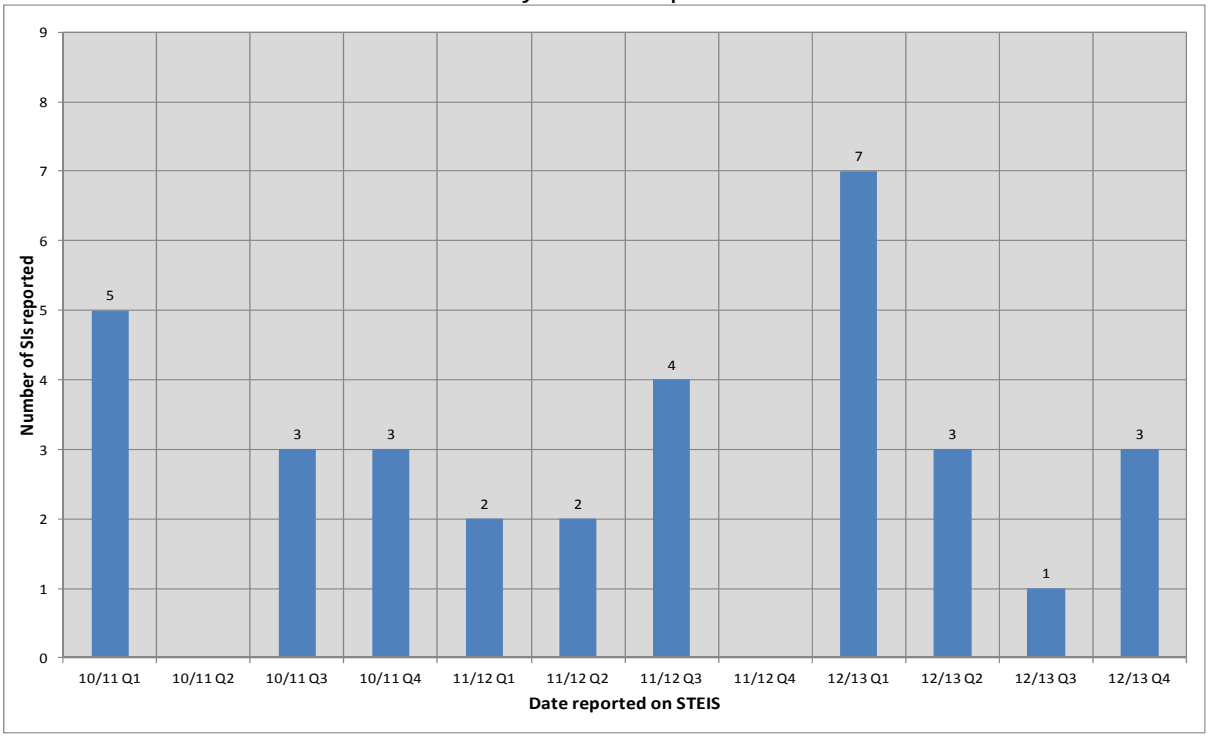


Chart W2 Wakefield Serious Incidents 2010/11 – 2012/13 by category

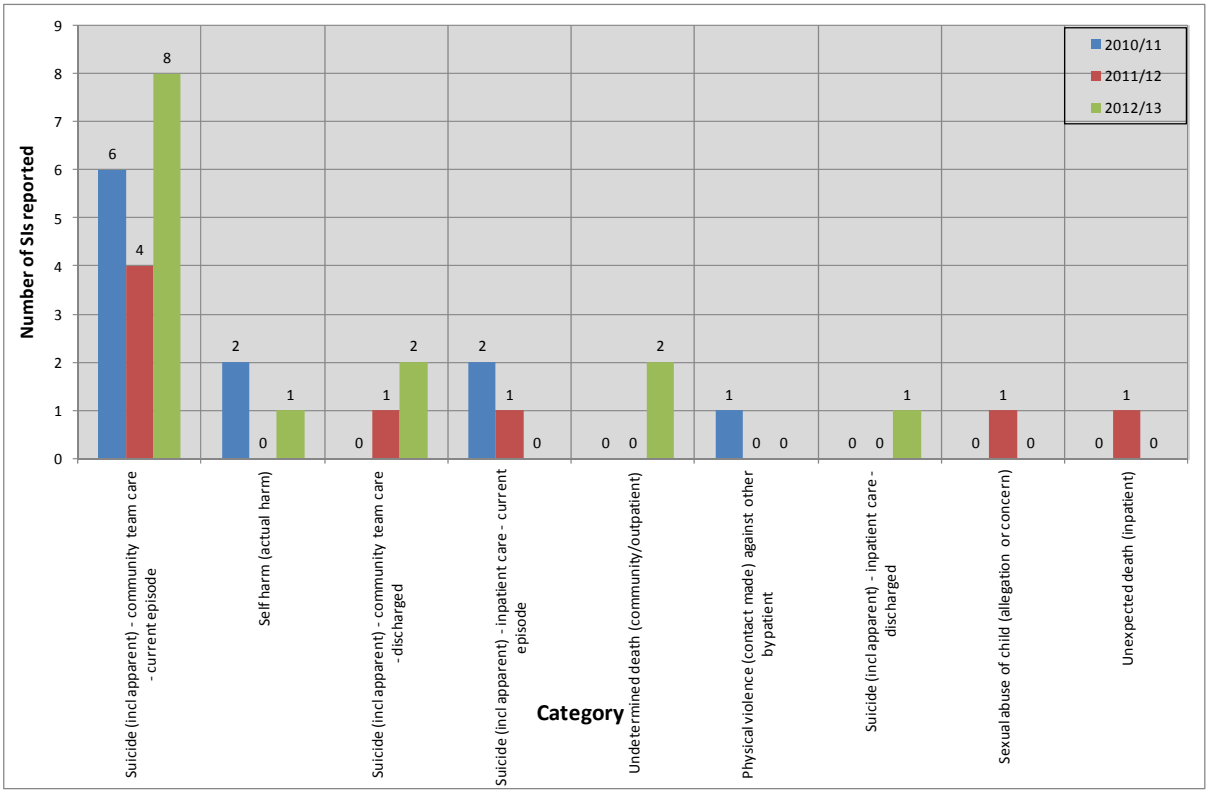


Chart W2 shows that suspected suicide is the highest category and that 2012/13 figures are one above what is expected from NCI data however the previous two years were as expected or below so it is difficult to draw any conclusions.

The National Confidential Inquiry figures July 2012 indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2000 to 2010 there are approximately 10.04 suicides per 100,000 general population each year. (range 8.6-11.2)
- On average during 2000-2010 patient suicides accounted for 27% of the general population suicide figures (range 2.4-3)

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

2012/13 - Incidence of suicide by Trust BDU populations and NCI suicides rates

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (27% general pop) (NCI)
Wakefield	337,152	29-37	8-10

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

Suspected Suicides reported on STEIS each quarter 2012/13

District	Qu1	Qu2	Qu3	Qu4	Total
Wakefield	5	3	1	2	**11**

Chart W3 Wakefield Serious Incidents 2012/13 by unit

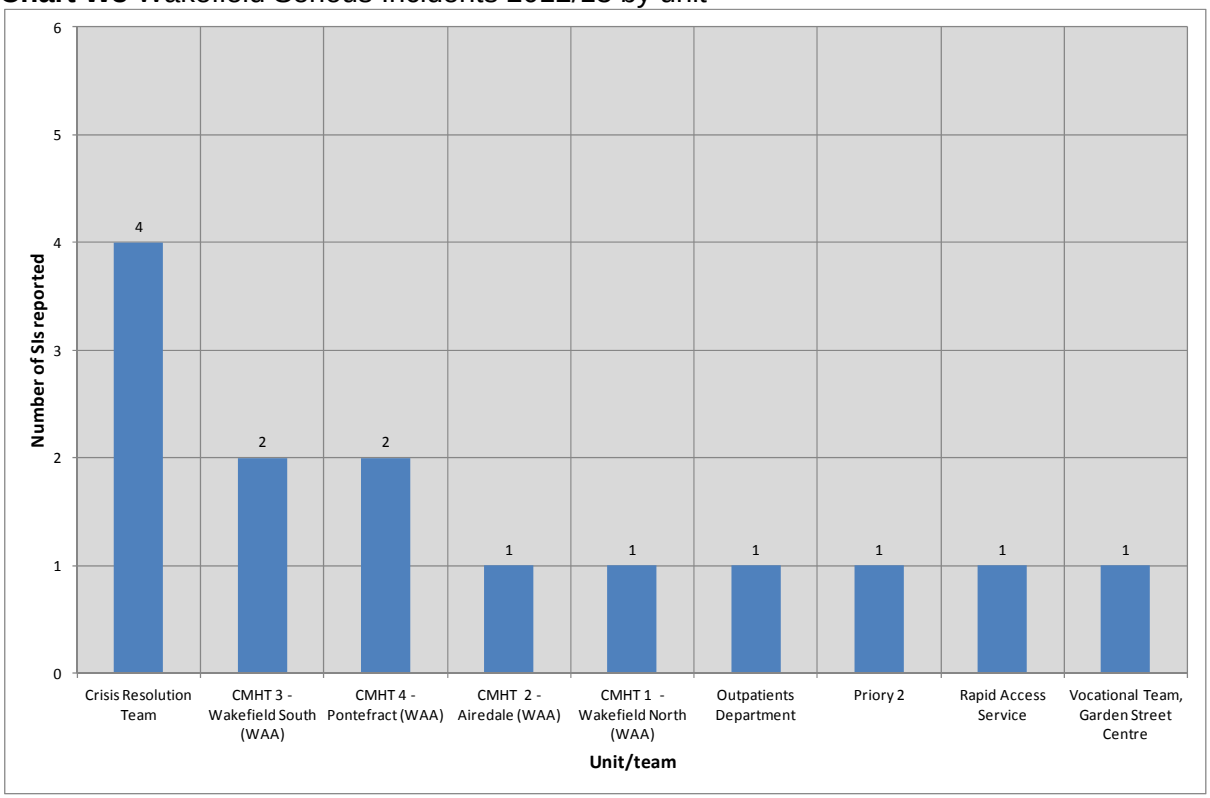


Chart W4: Wakefield Serious Incidents 2009/10 to 2011/12 by unit

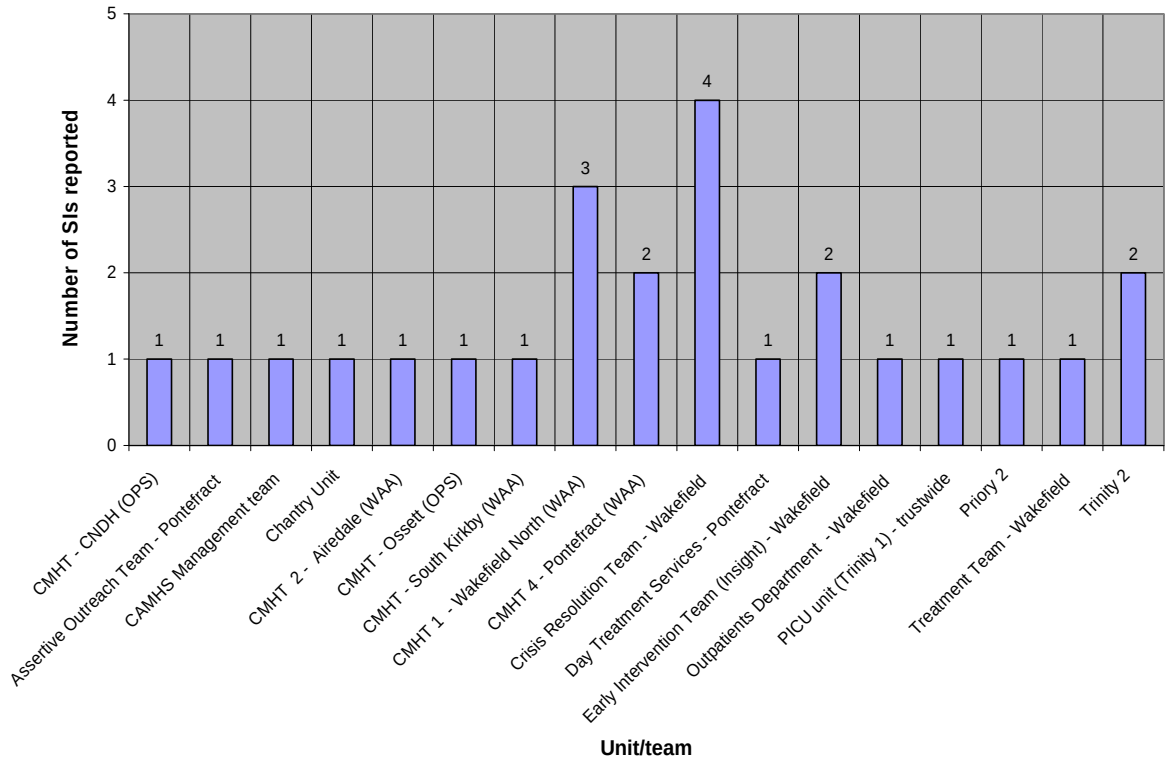


Chart W5 2012/13 recommendations for Wakefield SIs sent to Commissioners – by type

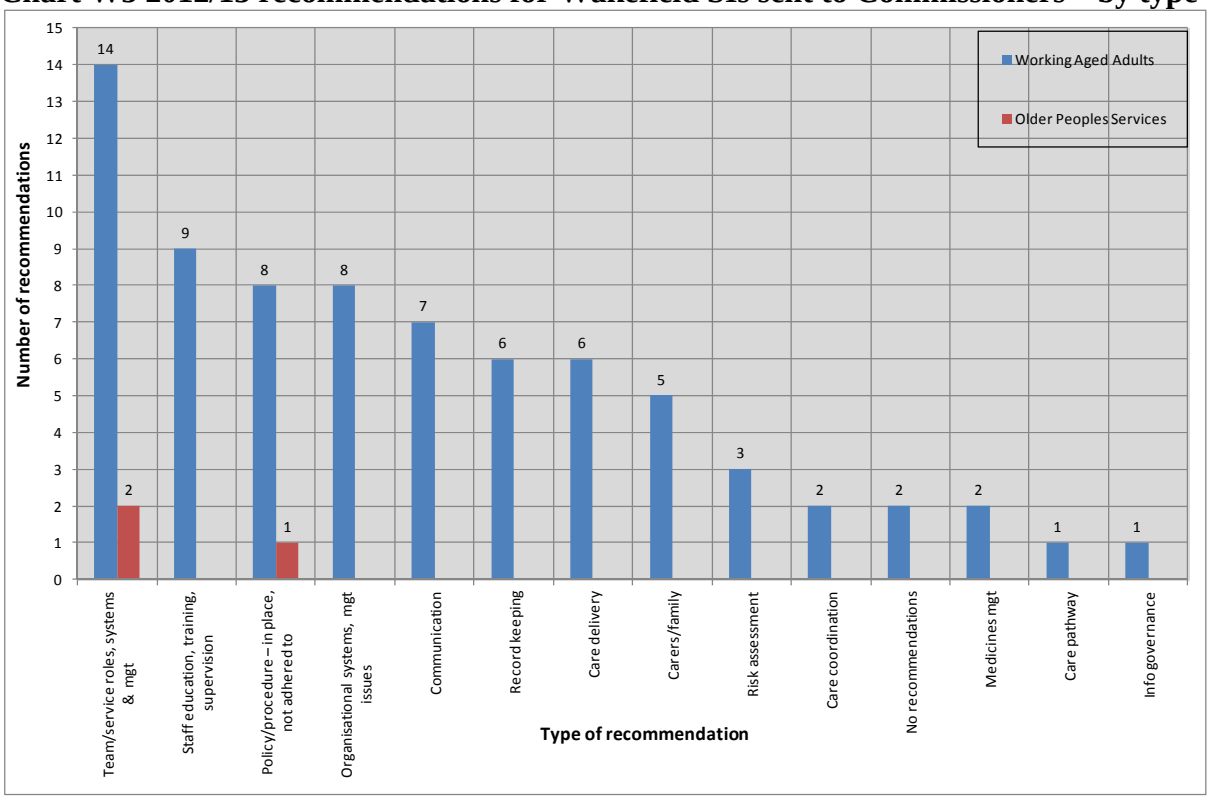


Chart W6: 2011/12 recommendations for Wakefield SIs sent to PCT by type

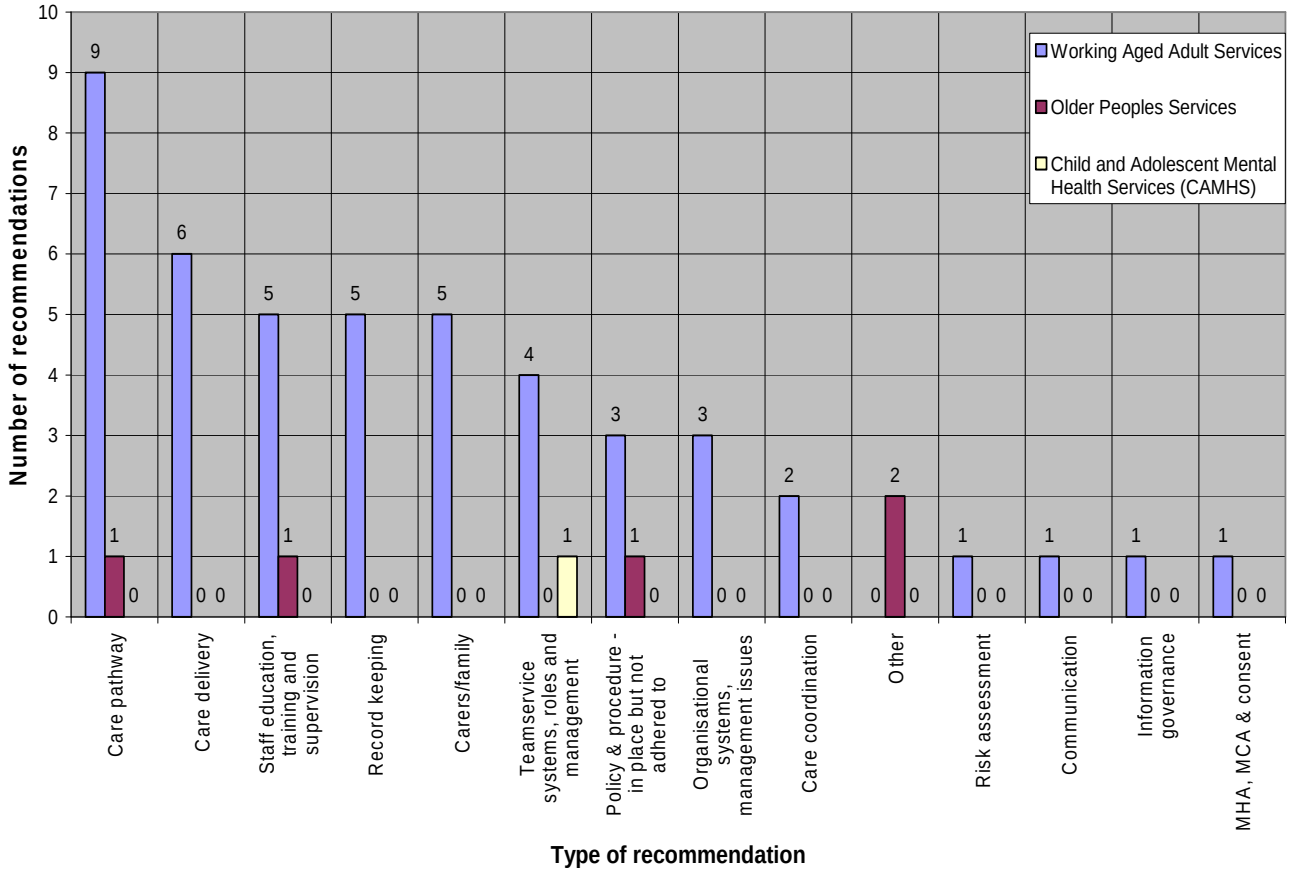


Chart W7 2012/13 recommendations for Wakefield SIs sent to Commissioners – by service

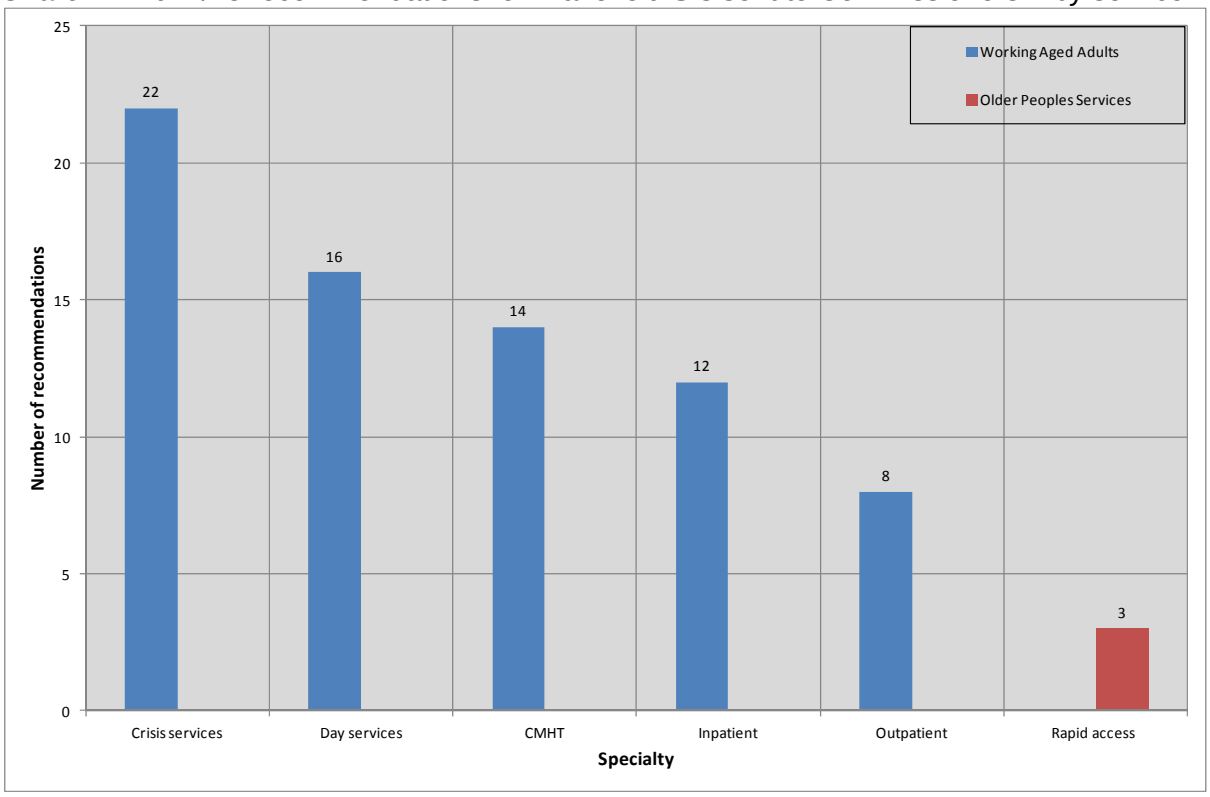
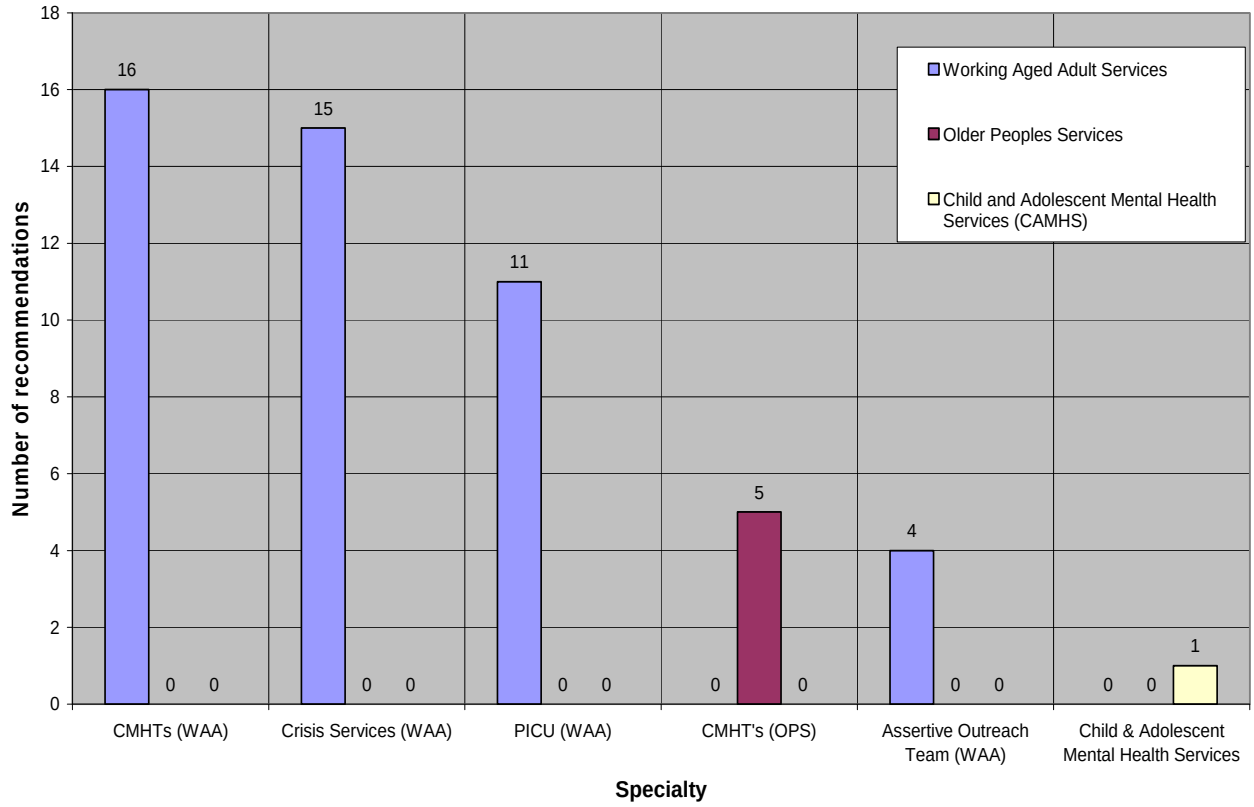


Chart W8: 2011/12 recommendations for Wakefield SIs sent to PCT by service/specialty.



Analysis of Forensic Services Serious Incidents April 2012 to March 2013

Chart F1 shows that Forensic services reported 1 serious incident; this is the same as the previous year. The incident type was self harm incident.
Chart F2 shows that the incidents over the previous 3 years have been different types although 2 were absconding.

Chart F1 Forensic Serious Incidents 2010/11 – 2012/13 by quarter

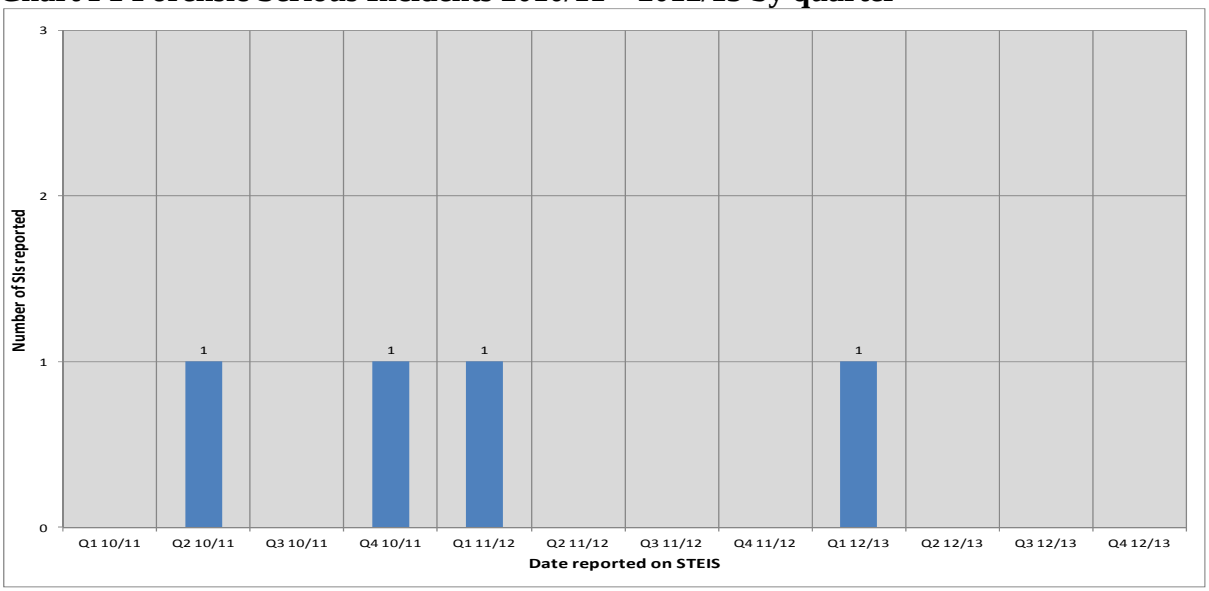
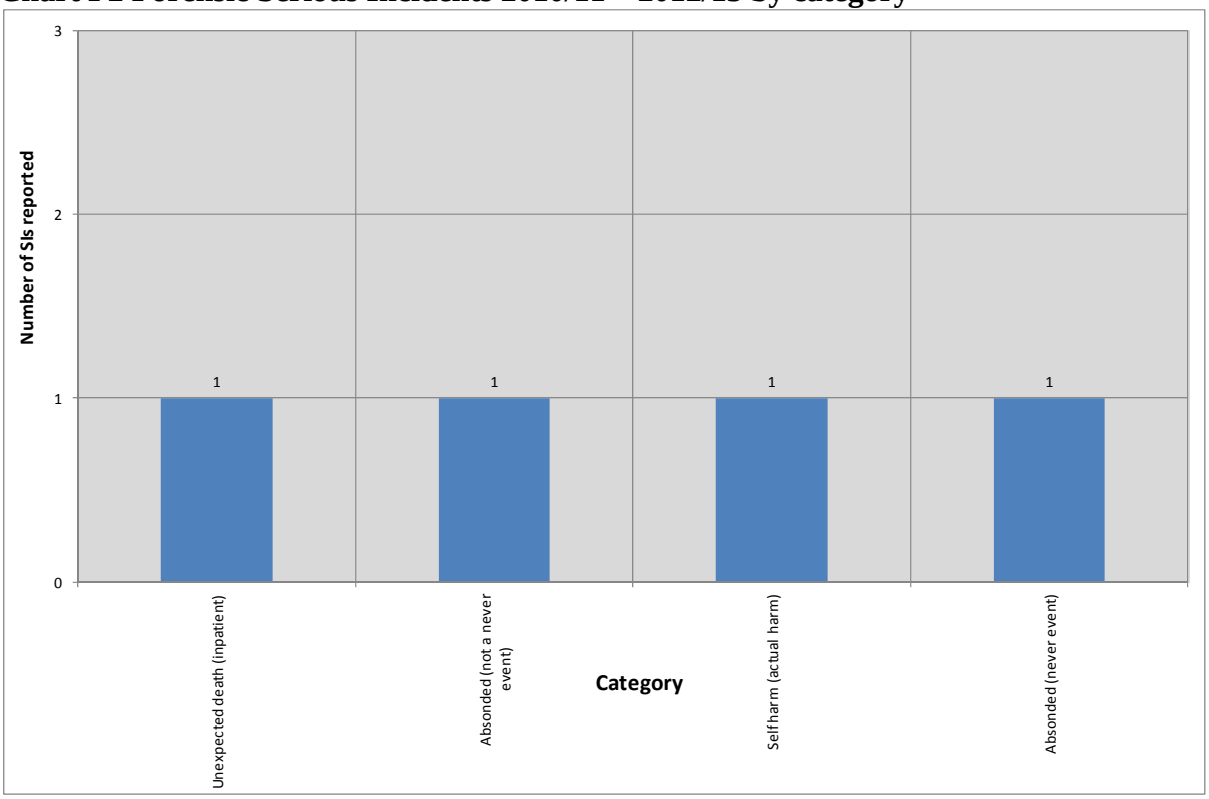
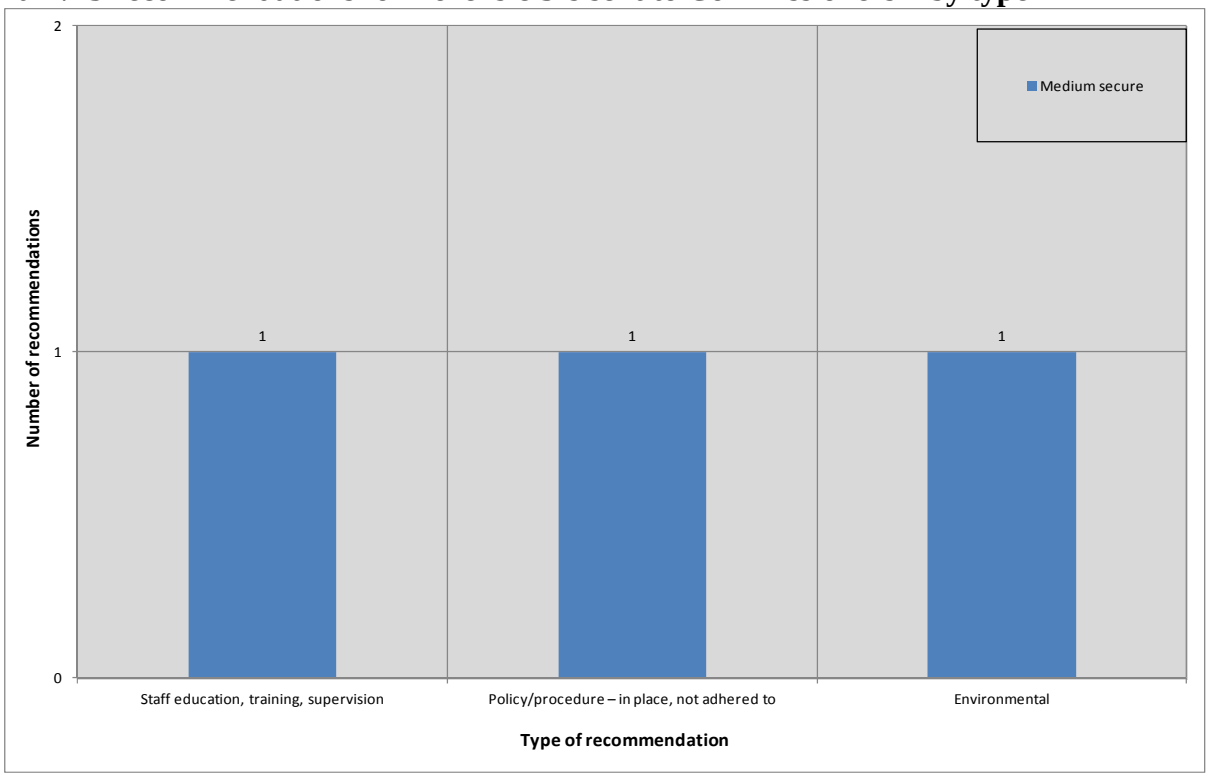


Chart F2 Forensic Serious Incidents 2010/11 – 2012/13 by category



Forensic Serious Incidents 2012/13 by unit
Bronte Ward – 1 incident

2012/13 recommendations for Forensic SIs sent to Commissioners – by type



2012/13 recommendations for Forensic SIs sent to Commissioners – by service
One report was submitted to the specialist forensic commissioners during 2012/13. This report related to a self harming incident of a service user in Medium Secure Services. This incident was *not* a never event. The report made 3 recommendations

- Staff training in relation to CPR and AED
- Storage of AED and oxygen
- CPA policy re registration of care coordinator

An action plan has been developed and implemented in relation to these.

	• develop/implement systems for collating, reviewing, advising on best practice and establishing appropriate board (and potentially commissioner) reporting on staffing, which would need to be linked to 'time to care', ward manager/team leader supervisory role considerations and quality impact assessments; • press forward with all initiatives to develop real time feedback mindful of government timetable for all service users to have access to real time feedback by 2015; • review recommendations from the Patients Association's peer review into complaints at Mid Staffordshire and improve complaints understanding with Clinical Commissioning Groups; • improve appraisal processes linked to professional portfolios; • clarify the ward manager role and job description and ensure emphasis on visible leadership and clinical focus can be achieved; • improve clinical record keeping, recording of capacity and consent; • ensure robust service specifications are in place aligned with clear outcome measures and fully utilise the contract board mechanism to influence considerations related to transformation service reviews; • implement clear mechanisms to ensure timely review of all expected external guidance/direction related to Francis and a communication strategy to ensure staff are engaged in the organisational response. **Identified Organisational Action:** <u>Response to staff feedback</u> • Communication strategy to be developed and implemented to enable key messages to be heard and have a significant influence on activity and behaviour at all organisational levels. • Staff feedback messages to be reviewed against the Organisational Development plan. • Staff feedback messages to be linked to transformational programme planning. • 'Closing the loop' actions to be supported and reinforced via Trust networks and groups. • Other channels, such as additional questions within the annual staff survey, to be explored to enable continued evaluation of staff perceptions against Francis recommendations. <u>Response to organisational assurance review</u> • Lead Directors agreed for each action area within the organisational assurance review with identified actions to be placed and implemented within specified workstreams. • Integration of review findings with Quality Governance Framework Board assurance processes (report September 2013). <u>Monitoring and Review</u> Progress against actions to be reviewed and reported to the Clinical Governance and Clinical Safety Committee in November 2013.
Recommendation:	**Trust Board is asked to approve the identified action.**
Private session:	Not applicable

Trust Board - 25 June 2013
Agenda item 7.3(iii)

Title:	**Customer Services Annual Report for the financial year 2012/13**
Paper prepared by:	Director of Corporate Development
Purpose:	This report is required as compliance with NHS complaints regulations and referred to in the Trust's Quality Account. Trust Board is asked to receive the report and note the learning as a consequence of feedback through the Trust's Customer Services function.
Vision/goals:	Good customer services is central to creating, fostering and maintaining a culture of continuous quality improvement, delivering the best possible outcomes for service users and ensuring families and carers are involved in care.
Any background papers/ previously considered by:	None
Executive summary:	This report covers the financial year 2012/13 and gives an overview of issues raised through the Customer Services function during the period. The Trust continues to place increased emphasis on understanding the experience of using Trust services to support service improvement and improved outcomes. Responding positively to feedback and resolving issues in 'real time' has to occur at every level of the organisation. During the period covered by the report: ➢ 289 formal complaints were investigated, with learning shared as appropriate; ➢ 234 informal concerns, 378 enquiries and 92 comments were made; ➢ 559 compliments were formally recorded and shared; ➢ 133 requests for information under the Freedom of Information Act were processed. The number of issues raised in the year showed an increase on the previous period reflecting the increased range of services provided and continued active promotion of the Customer Services function. The Team continues to work with staff to support a positive response to feedback, recognising that the vast majority of staff work hard to deliver the best service they can. The publication of the Francis Report and the changes to practice indicated by the Parliamentary and Health Services Ombudsman will potentially impact on the nature and volume of issues being raised in the coming period. There will be continued emphasis on sharing learning both within the organisation and on explaining to service users, carers, members and commissioners the actions taken by the Trust to improve services in response

	to feedback.
Recommendation:	**Trust Board is asked to note this overview of the management of issues raised through Customer Services in 12/13 and to refer to quarterly feedback contained in What Matters reports to note the broader approach being taken to customer feedback.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

TRUST BOARD – 25 JUNE 2013

CUSTOMER SERVICES - ANNUAL REPORT FOR THE FINANCIAL YEAR 1 APRIL 2012 TO 31 MARCH 2013

INTRODUCTION

This report fulfils the requirement identified in the audit of the Trust's Quality Account for 2012 - 13 to provide an annual report to Trust Board regarding the number and type of complaints received by the organisation. This is in compliance with regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. The report also provides an overview of Customer Services activity for the same period.

The report covers all feedback received by the team – comments, compliments, concern and complaints received in writing and treated as 'formal complaints' by the organisation. The Customer Services function offers one point of contact at the Trust for a range of enquiries and feedback.

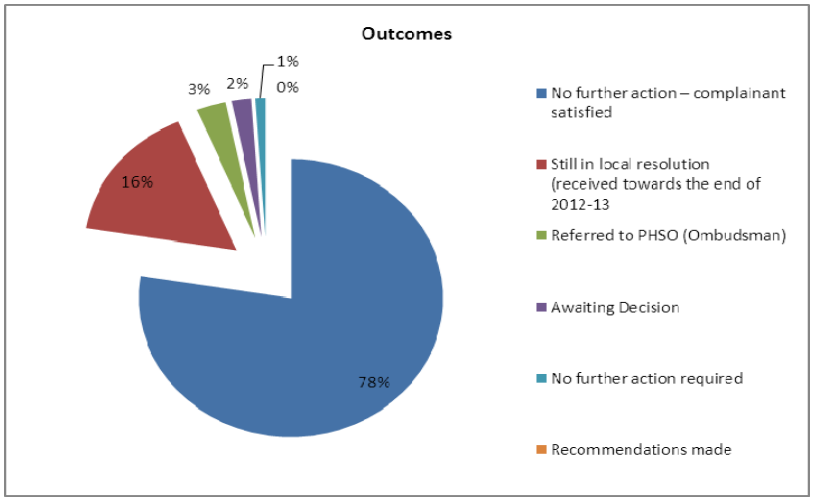
The report covers:

- the number of issues raised
- the themes arising
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received
- the number and type of requests processed under the Freedom of Information Act

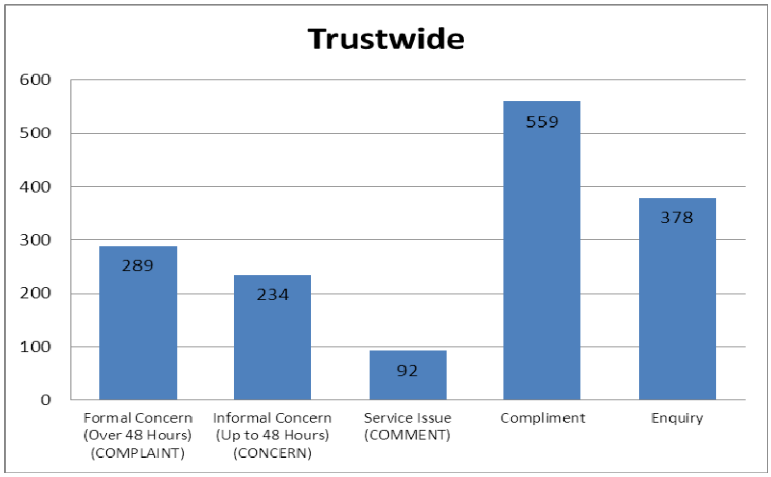
NUMBERS OF COMPLAINTS RECEIVED

The table below illustrates Customer Services activity in 2012 – 13. The total number of formal complaints received in the year was 289, which is an increase on the last two years, when 169 and 275 complaints were recorded respectively. This increase reflects the increased range of services now provided and perhaps the active promotion of the Customer Services function to service users, carers and staff and the wide distribution of materials explaining how to raise an issue to support improved service provision.

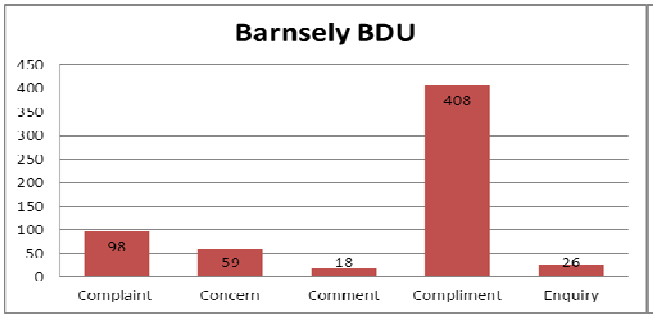
FORMAL COMPLAINTS PROGRESSION

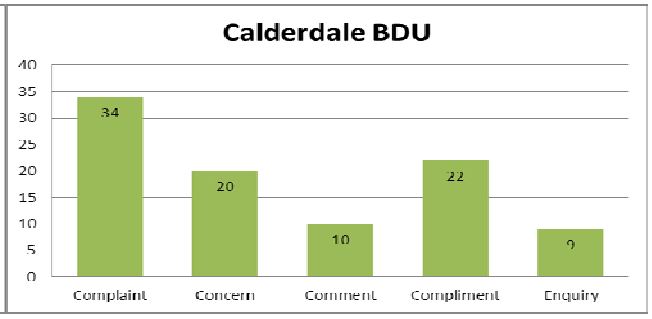


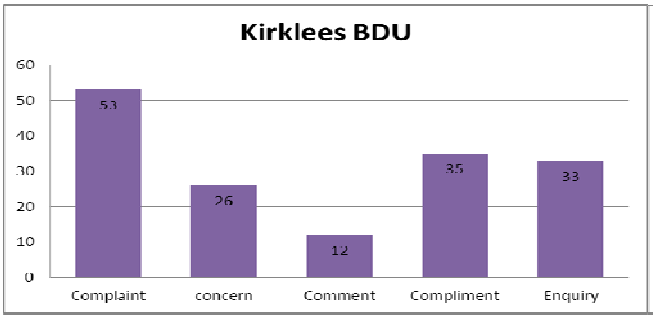
CUSTOMER SERVICES ACTIVITY 2012/13

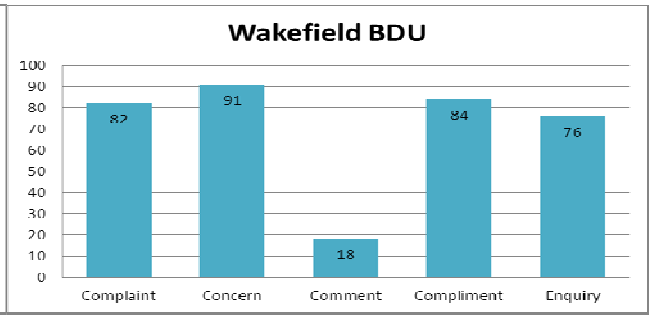


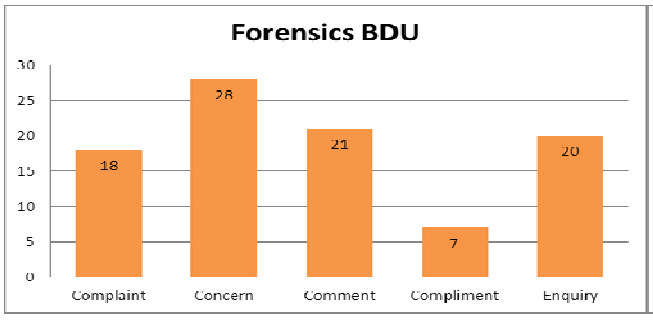
Can we show narrative in full in table above

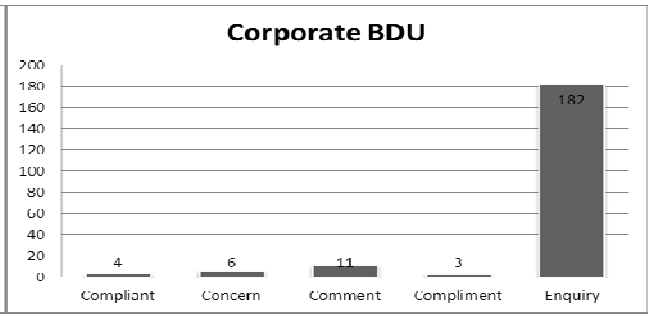












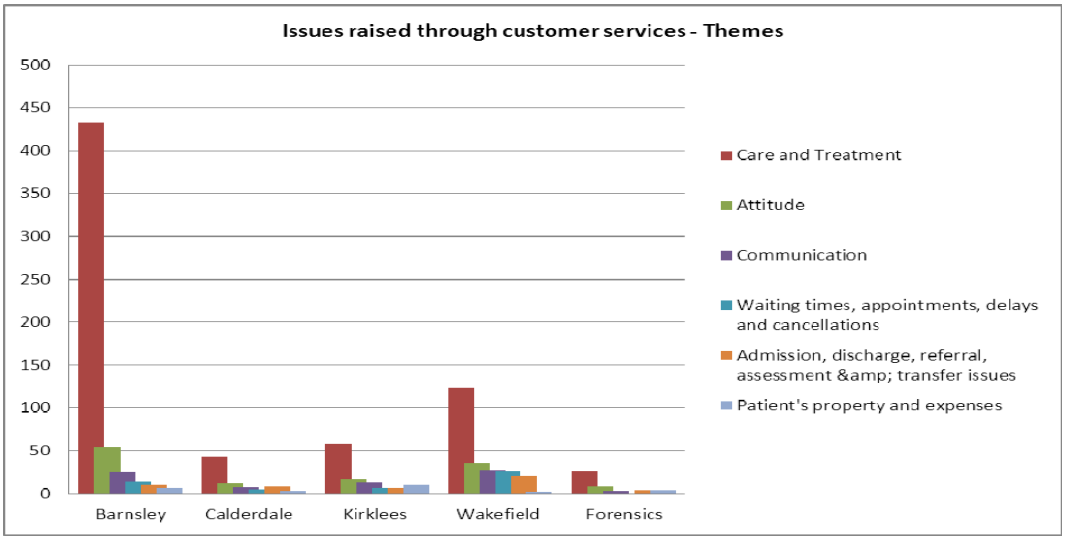
NUMBERS OF ISSUES RAISED INFORMALLY

During the year, Trust services responded to 326 issues of concern at local level. The Customer Services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right as and when they happen wherever possible and supports shared learning about service user and carer experience.

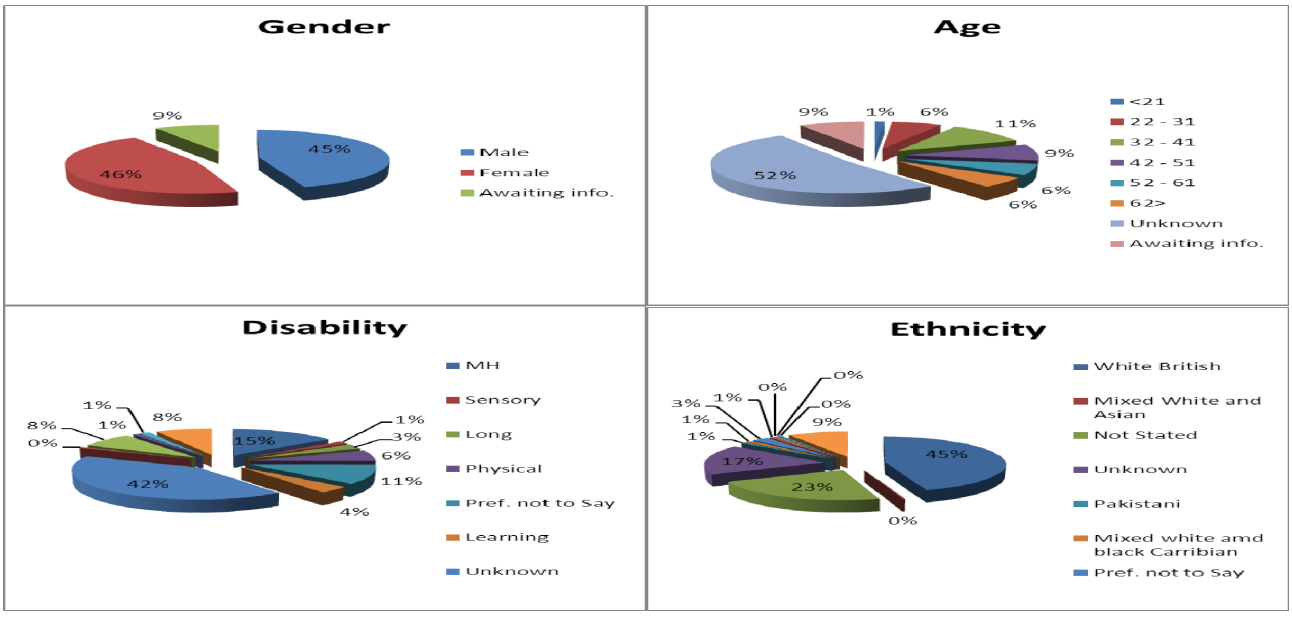
THEMES

Consistent with past reporting, care and treatment was the most frequently raised issue, with both positive and negative feedback offered (686). This was followed by staff attitude (128), communications (76), waiting times for appointments (51), admission, discharge and transfer issues (49) and service user property (25). Most complaints contained a number of themes.

Regular meetings are held with the Nursing Directorate to review / risk scan complaints and serious incidents to triangulate any issues of concern and assess the impact on service quality.



EQUALITY DATA



OMBUDSMAN INVESTIGATIONS

During the year, nine complainants asked for their cases to be reviewed by the Parliamentary and Health Service Ombudsman. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. The Trust has received notifications, during this period that the Ombudsman requires no further action on three cases that have been brought to their attention. Six cases are currently open with the Ombudsman; information has been submitted within the requested timeframe. One of the cases has been with the Local Government Ombudsman (acting also for the Parliamentary and Health Services Ombudsman) since November 2011. The delay in response is unexplained by the PHSO but the Trust has taken all required action.

MENTAL HEALTH ACT

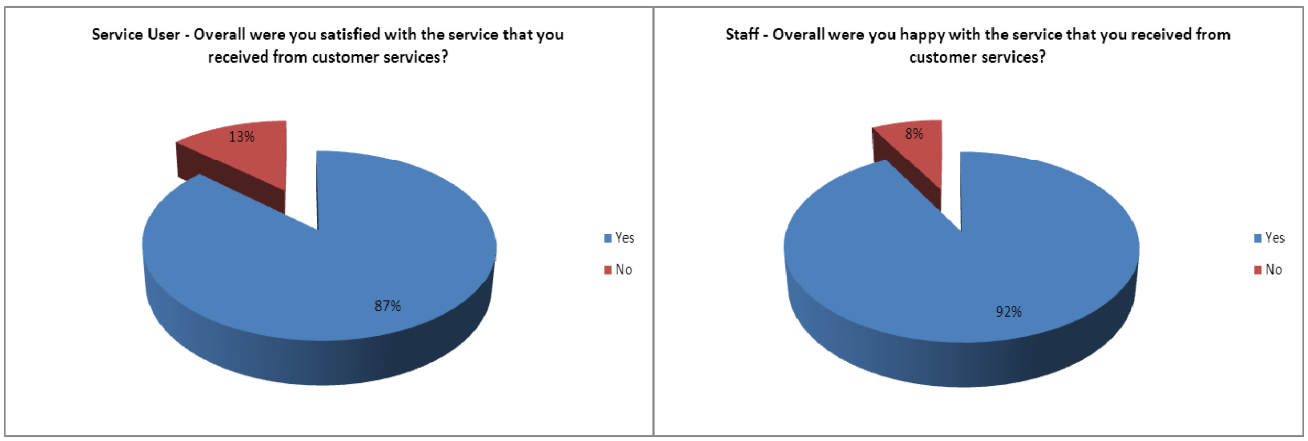
9 complaints were made in the year with regard to service user detention under the Mental Health Act. 4 of these were raised by people describing themselves as white British, 1 person described themselves as mixed white and black Caribbean and 4 elected not to specify ethnicity. Information on the numbers of complaints regarding application of the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

CUSTOMER SERVICES TEAM PERFORMANCE / CUSTOMER SATISFACTION

The Customer Services Team processed 378 enquiries in the financial year 2012 -13, including the provision of information regarding Trust Services, opportunities for voluntary work, signposting to Trust services, providing contact details for staff and signposting to involvement activities and dialogue groups. The team also responded to 167 staff enquiries offering support and advice in resolving concerns at local level.

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

A range of survey material has been introduced to evaluate the Customer Services offer and improvements have been made to processes in response to feedback.



COMPLIMENTS

During the year 559 compliments were recorded. These are acknowledged by the Chief Executive and positive feedback is shared with teams.

Some compliments received in year:

Each and every one of you are such caring individuals who genuinely care about people and I will always keep this experience in my heart.

I just wanted to say a huge thank you to all of you for helping me get back to myself, somewhere I thought I would never get again. I am enjoying life a lot and it is down to the input from you all.

You all helped me on my journey to recovery and I know I will be a better person for all the help so it's a big thank you from me to you.

Thank you for helping me and believing in me. You were the only one that understood me and what was wrong.

Each and every one of you are such caring individuals who genuinely care about people and I will always keep this experience in my heart.

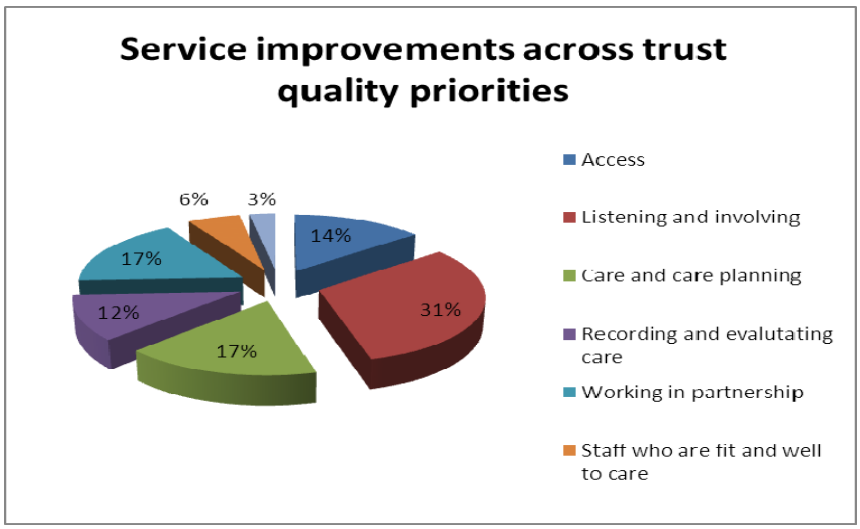
You have excellent, professional, caring and supportive staff. I truly feel listened to and completely supported. Your staff are a credit to your organisation and I hope their hard work and dedication is appreciated

Word cloud shows the key words quoted in compliments received in the period

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

Not all complaints require action plans to remedy issues, but all provide helpful feedback which is used in services to support service improvement. District Directors monitor the delivery of action plans and ensure that corrective action is implemented within service lines in response to trend analysis provided by Customer Services.

Most complainants meet with Trust staff to discuss their concerns. All complainants received a detailed response to the issues raised and an apology where appropriate. There were 35 action plans implemented in the last year as a direct consequence of service user feedback. Improvements were made across the Trust's quality priorities as follows:



SERVICE USER AND CARER STORIES

May was admitted to an older people's ward. She had some confusion and mobility issues. May was assessed for the risk of falling and required a plan to help her mobilise on the ward. The plan was not written up for four days and in that time May suffered a fall. Her family complained to the Trust about the care and treatment of their mother – about her deteriorating health, medication and that she fell whilst in our care. The Trust offered apology to May's family, explained to their satisfaction about the medication issues and explained what steps had been put in place to ensure that care plans are quickly updated following each clinical input. They remained concerned about the fall and asked the Parliamentary and Health Service Ombudsman to review the case. The PHSO are currently in dialogue with the Trust regarding closing this case.

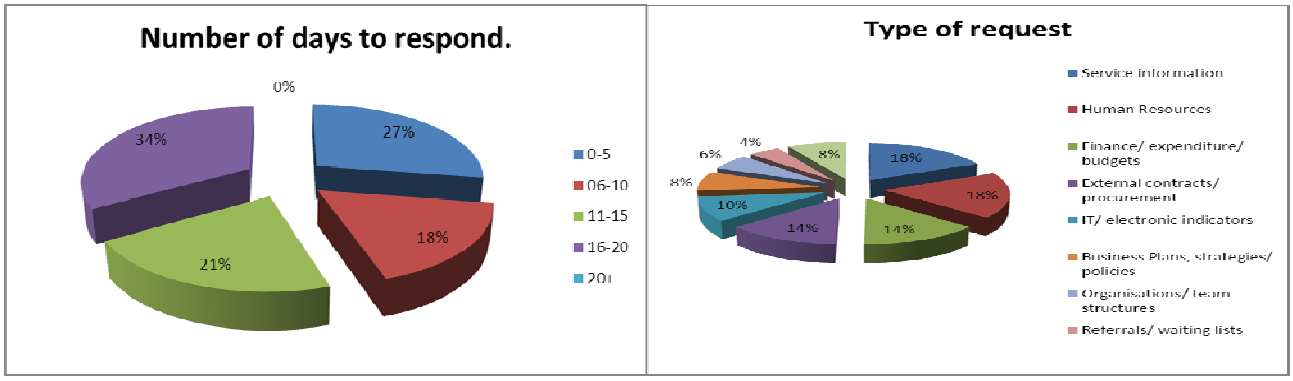
Ruth needed support from the district nursing service following hip surgery. She believed she received conflicting advice from the hospital and the district nursing service and complained to the Trust about poor care and communication. Ruth was unhappy that she had been advised by the hospital that she should not perform any self-care tasks as she risked dislocation of the hip. The district nursing team tried to encourage Ruth to self-care, for example changing her surgical stockings and washing her legs. Following this feedback all staff now follow up on the advice received by service users and in respect of hip surgery, do not expect the person to bend more than 90 degrees following surgery. Nurses are also to liaise more closely with care agencies to prevent any further misunderstandings of this nature, offering training and support to agency staff to improve and enhance patient care.

Tom was admitted to hospital requiring care from both his mental health and a physical illness for which he was also receiving support from local acute services. Tom was elderly and very unwell and unfortunately died after a spell in hospital. Tom's family were unhappy about the perceived lack of communication and co-ordination between the Trust and acute services and submitted a complex complaint raising 45 issues. Meetings were held with the family to offer condolences, to listen carefully to the issues and to agree an outcome that would help the family. The investigation highlighted learning for services and a number of improvements were put in place, for example increasing the involvement of families in care planning, signposting to other services such as the Alzheimer's Society, improving links with acute services, sharing of diagnostic information, scan results etc, and introducing training for staff in the use of a pain tool designed to improve pain recognition. The family, though devastated by their loss, were grateful for the efforts undertaken to investigate their concerns, for the close dialogue maintained with them as the investigation progressed and for the detailed feedback offered.

FREEDOM OF INFORMATION REQUESTS

133 requests to access information under the Freedom of Information Act were processed in the financial year 2012 -13. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

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



During the year, five requests were subject to exemptions - two were made under section 41, the duty of confidence and the public interest test, and three were made under section 40 of the Data Protection Act 1998, which protects access to personal detail.

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

LOOKING FORWARD

Customer Services efforts continue to focus on gathering insight on service user experience and to support teams to develop action plans to change and improve services as a consequence of feedback.

The Trust's Customer Services Policy: supporting the management of complaints, concerns, comments and compliments ensures compliance with national standards in respect of NHS complaints handling and takes

account of other relevant publications. The policy was revised in December 2012 to reflect the shift in operational management arrangements and an increased emphasis on gaining insight into service user experience and making continuous improvement as a consequence of feedback.

The Trust has a number of reporting mechanisms in place to monitor feedback:

- Complaints regarding staff attitude as a key performance indicator included in monthly performance reporting
- What Matters quarterly reports to Trust Board – a public facing document supplementing the assurance report. What Matters is structured around the Trust's quality priorities and gives a point in time snapshot of initiatives and actions to improve service user experience
- Quarterly Customer Services reports to BDUs and Quality Academy (and to commissioners)

The Trust continues to promote the importance of the best possible customer experience, for example:

- The Trust has introduced a training initiative 'Right First Time, Everytime' which has focussed on ensuring those important first contacts with people who use, or visit, our services are as good as they can be. The pilot courses have evaluated well and plans for roll out to all staff are being put in place as a means of supporting a positive service user experience and a default position of excellent customer services
- The Trust is currently being assessed against the national Customer Services Excellence standard. Assessment takes place across a range of criteria – customer insight, culture, information and access, service delivery and timeliness and quality of services. The assessment concludes in July with initial feedback on the final assessment day and an outcome formally reported within a few weeks. Preparation for the assessment has helped teams to review their performance in respect of all the criteria and showcase evidence and best practice to the external assessor.

A number of initiatives are and will continue to impact on Customer Services processes in the coming year, including:

- The Francis report has highlighted a range of issues in relation to complaints handling, including:
    - for service users and carers – active encouragement to raise issues about the experience of using services and the right to an explanation, apology and acknowledgement of responsibility, to understand what remedial action has been taken and for financial redress in some circumstances
    - for the Trust - to embed a culture of candour, openness and transparency, to continue to look for innovative ways to measure experience, to resolve issues quickly at local level wherever possible and to evidence the actions taken as a consequence of responding to feedback.
- The Parliamentary and Health Service Ombudsmen has indicted a shift in its approach to complaints review. Its published strategy for the next 5 years includes a commitment to have more impact for more people – to help improve services and help more people by investigating more complaints. Increasingly, NHS organisations are experiencing the PHSO suggesting financial redress as a means to close cases referred for review. This can be for direct or indirect financial loss, loss of opportunity, inconvenience or stress, or any combination of the same. The implications of this are currently being considered by the Trust and appropriate review and addition to policies and procedures will be put in place as required.

Trust Board 25 June 2013
Agenda item 7.3(iv)

Title:	**NHS Constitution**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the Constitution in delivering, planning and developing its services.
Vision/goals:	Meeting the rights and pledges in the NHS Constitution supports the Trust in meeting its vision and goals.
Any background papers/ previously considered by:	NHS Constitution January 2009 and papers to Trust Board in March 2010, September 2011 and September 2012. A full copy of the NHS Constitution can be found on the NHS website at www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
Executive summary:	The NHS Constitution was published in January 2009, following an extensive public consultation during 2008. It established the principles and values of the NHS in England and set out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required, by law, to take account of the Constitution in their decisions and actions. The Constitution also applies to public health services, which are now the responsibility of local authorities. The Government has committed to renewing the Constitution every ten years with the full involvement of patients who use the health service, the public who fund it and the staff who work in it. The first review took place in early 2012 and a further review was undertaken following the publication of the second Francis Report, published in March 2013. The Chair has asked that the annual report to Trust Board is brought forward to coincide with development of the Trust's action plan to address the Francis recommendations. <u>Key changes</u> A number of changes have been made to the NHS Constitution (the major changes are shown in italics in the attached paper). There are also changes to the wording of some rights and pledges although the meaning of these has not changed. Directors' attention is particularly drawn to the following. ➢ R5 no longer refers specifically to learning disabilities and mental health in terms of discrimination. ➢ As a result of the change to the wording of P3, the Trust can confirm that it meets the pledge as it endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care. There will be occasions when the nature of an individual's illness makes this inappropriate.

	➢ There is a pledge specifically relating to mixed sex accommodation (P6). ➢ Under 'Respect, consent and confidentiality', there is an increased emphasis on and strengthening of the commitments around confidentiality and the use of records with two new rights (R16 and R17) and four pledges (P8 to P11). ➢ In terms of complaints, there is a greater emphasis on the right to be informed as the investigation into a complaint progresses and includes an emphasis on learning lessons. ➢ In relation to staff responsibilities, there is a far greater emphasis on the duty to treat patients with dignity and respect, protecting patient confidentiality and data, and the duty to raise concerns.
Recommendation:	**Trust Board is asked to approve the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The NHS Constitution – patients and the public
How the Trust meets its obligations
Trust Board 25 June 2013

Heading	Compliance	Evidence	Further work required	Lead
Access to health services – rights				
➢ R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	Yes	Core services are commissioned by clinical commissioning groups covering the areas the Trust covers, Barnsley and Wakefield Councils, and NHS England (via the Secure Services Commissioning Team)	None currently.	AF
➢ R2 You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Yes	The Trust has contracts in place for its services with commissioners. The Trust's complaints process would identify any instances of where the Trust has not met or is perceived not to have met this right.		AF
➢ R3 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary *and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.*	N/A			
➢ R4 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	N/A			
➢ R5 You have the right not to be unlawfully discriminated against in the	Yes	The Trust complies with appropriate legislation relating to discrimination	Ongoing development	DS

Heading	Compliance	Evidence	Further work required	Lead
provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.		and has an Equality and Diversity Policy in place with a prime aim of respecting and valuing difference. The Trust uses the Equality Impact Assessment to evaluate the effect of its strategies and policies on its service users and the communities it serves and publishes these on its website. The Trust is implementing the Equality Delivery System.		
➢ R6 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.	N/A	The Trust does not provide services subject to waiting times as outlined in the Handbook to the NHS Constitution; however, the Trust does comply with targets related to services provided in Barnsley (also see below).		District Directors
Access to health services – pledges				
➢ P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution.	N/A	The Trust is not subject to the waiting times set out in the Constitution; however, the Trust is required to report on the referral to treatment times in relation to the Barnsley BDU consultant-led musculoskeletal service. The Trust meets the required timescale. As part of its contracts with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (IAPT) and psychological therapies. Access is one of the Trust's quality priorities set out in its Quality Accounts and performance is monitored and reported on a quarterly basis.	An action plan is in place to ensure the Trust meets its contractual targets in relation to IAPT and psychological therapies and its local CQUIN targets.	N/A

Heading	Compliance	Evidence	Further work required	Lead
➢ P2 The NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered.	Yes	The Trust has local CQUIN targets in relation to waiting times for mental health services, which are monitored and reported on a monthly basis. Public Trust Board meetings with minutes published on the Trust's website. Communication with the Trust's membership. Members' events held twice per year. Members' Council set up comprising elected public and staff Council Members and stakeholder representatives. Meetings held in public and papers and minutes published on Trust website. Involving People Strategy that outlines the Trust's approach to involvement and engagement. Service users and carers involved in planning and designing Trust services, including transformational service change programme.	Ongoing	DS
➢ P3 The NHS commits to make the transition as smooth as possible when you are referred between services, *and to put you, your family and carers at the centre of decisions that affect you or them.*	Yes	As a result of the change to the wording of this commitment, the Trust can now confirm that it meets the pledge as it endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care. There will be occasions when the nature of an individual's illness makes this inappropriate. There is also evidence that not all service users have a care plan in place and this is a priority area for the Trust in 2013/14. The Trust has a key performance	Improve systems and processes to ensure that all service users have a care plan in place and that they know who is responsible for their care. Work is progressing to develop/roll-out use of Recovery Star as a means of ensuring co-production of care plan with service users. Service user and their carer's perceptions are regularly reviewed through national and local surveys.	District Directors/TB

Heading	Compliance	Evidence	Further work required	Lead
		indicator in place in relation to service users being offered a care plan and is currently achieving its target..		
Quality of care and environment – rights				
➢ R7 You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	Yes	Compliance with CQC cores standards and requirements for registration. Compliance with NICE guidelines. Employment checks. Ongoing Continuous Professional Development. Human Resources and Workforce Development Strategy including mandatory training plan in place.		TB/AGD/NHB
➢ R8 You have the right to expect NHS organisations to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. *This includes improvements to the safety, effectiveness and experience of services.*	Yes	Performance and other reports to Trust Board and its Committees. These reports are publicly available on the Trust's website. Transformational service change programme in development phase with engagement and involvement events planned for June and July 2013. Dedicated website pages and inclusion in Like Minds, supported by three-year annual plan to Monitor and change management programme. Ongoing development of the Quality Academy approach, including identification of quality champions. Trust's own programme of unannounced visits to all locations registered with the Care Quality Commission where compliance with essential standards is reviewed. The Trust currently has no compliance actions as a result of unannounced visits by the Care Quality Commission and has put processes in place to	Ongoing	AF/TB

Heading	Compliance	Evidence	Further work required	Lead
		learn from the outcome of previous visits to the Trust.		
Quality of care and environment – pledges				
➢ P4 The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.	Yes	Establishment of a Trust Board level Estates Forum. Estates Strategy and six-facet survey The latest round of PEAT visits continue to result in a positive outcome.	Programme of continuous improvement in place	AGD/District Directors
➢ P5 The NHS commits to identify and share best practice in quality of care and treatments.	Yes	See transformational change programme above. Ongoing development of the Quality Academy approach. Development of quality approach through initiatives such as the Change Lab and Creative Minds.	Ongoing	District Directors
➢ *P6 The NHS commits that, if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.*	Yes	The Trust is able to make a declaration that it complies with the national standard in relation to Eliminating Mixed Sex Accommodation.		TB
Nationally approved treatments, drugs and programmes – rights				
➢ R8 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you.	Yes	The Trust is generally compliant with NICE guidance. Trust has a policy and procedures with timelines to implement NICE guidance.	New NICE guidance is implemented as NICE guidance implementation practice.	TB
➢ R9 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they	N/A			

Heading	Compliance	Evidence	Further work required	Lead
will explain the decision to you. ➢ R10 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.	N/A	This is a right for commissioners; however, the Trust is commissioned to deliver vaccination and immunisation by NHS Barnsley and has two service level agreements to deliver childhood immunisations through health visitors. Where the Trust is commissioned to provide such services, it complies with its obligations.	None	District Director
Nationally approved treatments, drugs and programmes – pledges				
➢ P7 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	N/A	Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley BDU.	None	District Director
Respect, consent and confidentiality – rights				
➢ R11 You have the right to be treated with dignity and respect, in accordance with your human rights.	Yes	Staff work to professional codes of conduct, Trust policies and CPA standards. The Trust's Equality and Diversity Policy sets out how the Trust accords to an individual's human rights.	None	NHB/District Directors/DS/ TB
➢ R12 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental Health Act 1983.)	Yes	Consent Policy. The Trust has clear policies and procedures in place for the administration of the Mental Health Act. Mental Capacity Act Policy.	None	NHB/TB

Heading	Compliance	Evidence	Further work required	Lead
➢ R13 You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Yes	Trust has medicine information leaflets including translation into other languages if required. Trust provides choice leaflets for some groups of medication. Service user information leaflets, which set out service user rights. Service users are given copies of their care plans. Service users and carers part of developing Trust approach to care planning.	Ongoing engagement with service users and carers, particularly around CPA.	TB/NHB
➢ R14 You have the right of access to your own health records and to have any factual inaccuracies corrected.	Yes	Patient Identifiable Information Policy – service user access Freedom of Information Policy Trust complies with requirements of Information Governance Toolkit, NHS LARMS and CQC registration.	None	AF/DS
➢ R15 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure	Yes	Trust meets DoH privacy and dignity guidance and has made a declaration of compliance to Monitor and to service users regarding elimination of mixed sex accommodation. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area.	None	TB AF
➢ *R16 You have the right to be informed about how your information is used.*	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. Trust complies with the requirements of the Information	None	AF/DS

Heading	Compliance	Evidence	Further work required	Lead
➢ *R17 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be followed, to be told the reasons, including the legal basis.*	Yes	Governance Toolkit and Department of Health requirements to train staff in this area. Service user information.	None	AF/DS
Respect, consent and confidentiality – pledges				
➢ *P8 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively.*	Yes	The Trust has one clinical information system, RiO, across its business delivery units. The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols in place with partners as appropriate.	Continued development of RiO and of interoperability.	AF
➢ *P9 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others.*	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area.		AF
➢ *P10 The NHS commits, where identifiable information is used, to give you the chance to object wherever possible.*	Yes	As above.		AF
➢ *P11 The NHS commits to inform you of research studies in which you may eligible to participate.*	N/A			

Heading	Compliance	Evidence	Further work required	Lead
➢ P12 The NHS commits to share with you any letters sent between clinicians about your care.	Yes	All service users have access to their clinical records (Patient Identifiable Information Policy – service user access) Service users are offered a copy of their care plan Service users receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing.		AF/TB/District Directors
Informed choice – rights				
➢ R18 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	N/A			
➢ R19 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	N/A			
➢ R20 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs.	Yes	Through verbal discussions, development of individual care plans and patient information leaflets (multilingual on request)	None	DS/District Directors
Informed choice – pledges				
➢ P13 The NHS commits to inform you about the healthcare services available to you, locally and nationally.	Yes	Information available on the Trust's website and in information leaflets. Development of a service directory.	None	DS/District Directors
➢ P14 The NHS commits to offer you easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support	Yes	Information available on Trust's website, in information leaflets and the Trust's Quality Accounts. The Trust's service offer by district is available on its website. Service user experience is	None	DS/TB/District Directors

Heading	Compliance	Evidence	Further work required	Lead
you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.		summarised in a quarterly document, "What Matters?", also available on the Trust's website.		
Involvement in your healthcare and in the NHS – rights				
➢ R21 You have the right to be involved in discussions and decisions about your healthcare, including your end of life care, and to be given information to enable you to do this. Where appropriate, this right includes your family and carers.	Yes	As above. The Trust offers and has available interpreter services either face-to-face or by telephone.	None	District Directors/DS
➢ R22 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting the operation of those services.	Yes	Members' Council and Trust membership. Members' events twice-yearly. Involving People Strategy in place. Dialogue groups in all districts. Trust service users/carers on local partnership boards. Information provided to local Healthwatch. Communication and engagement events in relation to the Trust's transformational change programme.	Ongoing	DS
Involvement in your healthcare and in the NHS – pledges				
➢ P15 The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.	Yes	As above	Ongoing	DS
➢ P16 The NHS commits to work in partnership with you, your family, carers and representatives.	Yes	As above	Ongoing	District Directors/DS
➢ *P17 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.*	Partly	Service users are offered a copy of their care plan. The Trust endeavours to consult and involve all service users and, where		District Directors

Heading	Compliance	Evidence	Further work required	Lead
		appropriate, their carers, in decisions about their care. There will be occasions when the nature of an individual's illness makes this inappropriate.		
➢ *P18 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.*	Yes	The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement. The quarterly service user experience document, "What Matters", demonstrates how the Trust uses patient experience information and feedback.	Ongoing development	DS
Complaints and redress – rights				
➢ R23 You have the right to have any complaint you make about NHS services *acknowledged within three working days* and to have it properly investigated.	Yes	Complaints Policy and Customer Service Team structure. Performance measures in place.	Ongoing	DS
➢ *R24You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.*	Yes	As above	Ongoing	DS
➢ R25 You have the right to *be kept informed of the progress and to* know the outcome of any investigation into your complaint, *including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.*	Yes	Complaints Policy and Customer Service Team structure.	Ongoing	DS
➢ R26 You have the right to take your complaint to the independent	Yes	Complaints Policy, information on Trust websites and patient information	Ongoing	DS

Heading	Compliance	Evidence	Further work required	Lead
Parliamentary and Health Service Ombudsman *or Local Government Ombudsman* if you are not satisfied with the way your complaint has been dealt with by the NHS.				
➢ R27 You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body *or local authority.*.	Yes	Complaints Policy and information on Trust websites	None	DS
➢ R28 You have the right to compensation where you have been harmed by negligent treatment.	Yes	Claims Management Policy	None	TB
Complaints and redress – pledges				
➢ R19 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not adversely affect your future treatment.	Yes	Complaints Policy and Customer Service Team structure	None	DS
➢ P20 The NHS commits *to ensure that*, when mistakes happen *or if you are harmed while receiving health care*, *you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.*	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts.	Ongoing	TB
➢ P21The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.	Yes	Evidenced by action plans arising out of incident reports and Independent Inquiry reports and through reports to Clinical Governance and Clinical Safety Committee and Trust Board. Establishment of Incident Review Sub-Committee of Clinical Governance and Clinical Safety Committee.	Ongoing	TB/NHB

The NHS Constitution also sets out nine responsibilities of patients and the public.

- Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- Please provide accurate information about your health, condition and status."
- Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.
- Please participate in important public health programmes such as vaccination.
- Please ensure that those closest to you are aware of your wishes about organ donation.
- You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

The NHS Constitution – staff
How the Trust meets its obligations

Heading	Compliance	Evidence	Further work required	Lead
The rights are there to help ensure staff:				
➢ have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;	Yes	HR policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Also Harassment and Bullying Policy and Grievance Policy and Procedures in place		AGD
➢ have a fair pay and contract framework;	Yes	HR Strategy. Trust pay structure based on Agenda for Change and Trust follows guidance issued by National Pay Bodies as appropriate. HR Policies and Procedures as above HR Strategy sets out Trust approach to pay.		AGD
➢ can be involved and represented in the workplace;	Yes	Disciplinary Policy and Procedures. Grievance Policy and Procedures Set out in the Social Partnership Agreement between the Trust and staff side organisations		AGD
➢ have healthy and safe working conditions and an environment free from harassment, bullying or violence;		HR policies and procedures Staff survey Health and Safety Policy Risk assessments of workplace Managing Aggression and Violence lead in place with supporting MAV TAG		AGD
➢ are treated fairly, equally and free from discrimination;		HR policies and procedures		AGD
➢ can, in certain circumstances, take a		Disciplinary and Grievance Policies		AGD

Heading	Compliance	Evidence	Further work required	Lead
complaint about their employer to an Employment Tribunal;		and Procedures		
➢ can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.		HR Policies and Procedures Information given to staff Whistleblowing Policy		AGD

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

- *The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.*
- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- *The NHS commits to have a process for staff to raise an internal grievance.*
- The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

- To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
- To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to maintain the highest standards of care and service, *treating every individual with compassion, dignity and respect,* taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- *You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.*
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged *and colleagues are supported where errors are made*.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- *You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.*
- *You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.*
- *You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.*
- *You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.*

Trust Board 25 June 2013
Agenda item 7.3(v)

Title:	**Registration for additional activity with Care Quality Commission**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety (as lead Director for compliance)
Purpose:	The paper provides Trust Board with the information required to approve the Trust's application to the Care Quality Commission (CQC) to amend its registration and to change its Statement of Purpose, which has to be submitted with the application.
Vision/goals:	Compliance with the requirements of registration with the Care Quality Commission is part of the Trust's licensing conditions and is a key part of its clinical governance arrangements.
Any background papers/ previously considered by:	Trust Board is aware of the process required from previous applications to the CQC.
Executive summary:	<u>Background</u> Barnsley Business Delivery Unit (BDU) delivers a Department of Health-funded programme, the Family Nurse Partnership (FNP), which is a preventative programme offered to first-time mothers in the form of intensive, individual support. The same family nurse (a nurse who has received additional training from the Department of Health to deliver FNP) works with families until the child is two. The primary focus is the future health and wellbeing of the child and mother. <u>Ground Family Nurse Partnership</u> The BDU has made a successful submission to participate in a trial to test the delivery of the Group Family Nurse Partnership (GFNP). This is aimed at mothers who are currently ineligible to receive FNP (primarily those under 24 in their first pregnancy or under 20 in their second pregnancy who have not already received support under FNP) within a group setting. This is a national scheme supported by NHS England. Recruitment to the trial is anticipated to commence in July 2013 with the group to begin in September 2013. The group will be run by two experienced family nurses and supported by the FNP supervisor. Midwifery (ante- and post-natal) care is provided within the group setting; therefore, one of the family nurses must be a Registered Midwife. There is no intention to offer other types of maternity and midwifery service/care outside of this specific project. There is no additional funding resource attached to this trial. The input into the project comes from within the current staffing levels and this has been planned in. <u>Management and accountability</u> The service will be subject to the Trust's clinical and corporate governance processes to ensure compliance with regulations relevant to the regulated activity and in accordance with Trust risk and safety (including safeguarding) policy and processes. Management and overall FNP project accountability

	will be through the Assistant Director of Children's Health Improvements to the District Director for Barnsley. Professional accountability is through the Assistant Director of Children's Health Improvements to the Director of Nursing, Clinical Governance and Safety. Direct supervision for the midwife will be provided by the Head of Midwifery, Barnsley Hospital NHS Foundation Trust (BHFT) in line with professional regulatory requirements. The necessary care pathways are in place for delivering safe, effective midwifery care. The family nurse/midwife has honorary contract status (which is an agreement allowing an individual access to facilities without being employed or paid by the organisation) with BHFT, will work to its midwifery practice policies and procedures, and directly access relevant BHFT information systems. Ongoing monitoring and reporting against the project will be through Barnsley BDU governance group (chaired by the District Director) and through to the Clinical Governance and Clinical Safety Committee. <u>Proposal</u> The Trust is not currently registered with the CQC to provide maternity and midwifery services. As it is an offence under section 10 of the Health and Social Care Act 2008 to carry on a regulated activity without being registered by the CQC, the Trust is required to seek an addition to its registration and to amend its Statement of Purpose. There is no financial impact in terms of the current CQC fee structure through the registration of this activity.
Recommendation:	**Trust Board is asked to approve the application and an amendment to the Trust's Statement of Purpose, which reflects this registration status change.**
Private session:	Not applicable.

Trust Board 25 June 2013
Agenda item 8

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.
Vision/goals:	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. The seal has been used five times since the report to Trust Board in March 2013 in respect of: 1. the novation of a contract for substance misuse services between Bexley PCT, Bexley Council and the Trust; 2. a licence to occupy a room at the Al-Hikmah Centre in Batley; 3. a national variation deed with NHS Tameside and Glossop CCG in relation to the NHS Standard Contract for podiatry services under Any Qualified provider; 4. the lease at Garden Street, Wakefield, between Yorkshire Property and Investment Company Limited and the Trust; 5. an option agreement relating to land at Aberford Lane, Wakefield, between Miller Homes Limited and the Trust.
Recommendation:	**Trust Board is asked to note use of the Trust's seal since the last report in March 2013.**
Private session:	Not applicable