With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board public session
Tuesday 25 March 2014 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 28 January 2014

4. Assurance from Trust Board Committees
- 4.1 Audit Committee 21 January 2014
- 4.2 Clinical Governance and Clinical Safety Committee 11 February 2014
- 4.3 Mental Health Act Committee 25 February 2014
- 4.4 Remuneration and Terms of Service Committee 4 February 2014

5. Chief Executive's report

6. Corporate objectives 2014/15

7. Performance reports month 11 2013/14

7.1 Section 1 – Integrated performance report month 11 2013/14 (to follow)

7.2 Section 2 – Finance report month 11 2013/14

7.3 Exception reporting and action plans
- (i) Information Governance Toolkit
- (ii) Eliminating mixed sex accommodation annual declaration

8. Governance issues

8.1 Annual plan 2014/15 to 2015/16 and budgets 2014/15 (to follow)

8.2 Annual Governance Statement 2013/14

8.3 Monitor Code of Governance

8.4 Monitor Licence – compliance and risk assessment

9. Use of Trust seal

10. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 29 April 2014 in the Shibden room, 5th Floor, F Mill, Dean Clough, Halifax.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 2

Title:	**Trust Board declaration of interests**
Paper prepared by:	Director of Corporate Development on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Vision/goals:	The vision and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	None
Executive summary:	The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executives have signed a declaration to this effect. The Integrated Governance Manager is responsible for administering the process on behalf of the Chief Executive of the Trust and the Company Secretary. The declared interests of the Chair and Directors are reported in

	the annual report and the register of interests is published on the Trust's website. Following an assessment of the Trust's approach to the Bribery Act, a paper was presented to the Audit Committee in January 2014 to provide assurance to the Committee on the Trust's declaration processes currently in place for Trust Board, the Members' Council and staff. There were no actions to be taken with regard to the processes for Trust Board and the Members' Council as both were considered to be robust and appropriate by internal audit; however, a number of recommendations were made in relation to the staff process. These were supported by the Committee and will be implemented during 2014. The Committee will also receive, on behalf of Trust Board, an annual risk assessment of the register of interests for Trust staff in September of each year to provide assurance to Trust Board that any declared interests have been assessed and managed appropriately.
Recommendation:	**Trust Board is asked to consider the attached Declaration of Interests and, subject to any comment, amendment or other action, to formally note the details in the minutes of this meeting.**
Private session:	Not applicable

Trust Board – Declaration of Interests
25 March 2014

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

The following declarations of interest were made by Directors.

Name	Declaration
CHAIR	
Ian Black	Non-Executive Director, Benenden Healthcare (mutual) Non-Executive Director, Seedrs (with small shareholding) Private shareholding in Lloyds Banking Group PLC (retired member of staff) Chair, Family Fund (UK charity) Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	Director, Honley Show Society Ltd.
Bernard Fee	No interests declared
Julie Fox	No interests declared; however, does work with the Care Quality Commission in work and inspection with children and young people who offend and child protection issues. This is not likely to conflict with the non-executive director role.
Jonathan Jones	Member, Squire Sanders (UK) LLP Member, Squire Sanders MENA LLP Spouse, shareholder in Barcelona Hold Co (holding company of Zenith Vehicle Contract Limited)
Helen Wollaston	Director, Equal to the Occasion (consultancy) Director, WISE (Women in Science and Engineering) Partner is Fitness to Practice Panellist with the Medical Practitioners' Tribunal Service
CHIEF EXECUTIVE	
Steven Michael	Member of Huddersfield University Business School Advisory Board Member, Leeds University International Fellowship Scheme Partner, NHS Interim Management and Support Trustee, Spectrum People NHS Confederation selected Chief Executive representative, Mental Health Network Board Health and Wellbeing Boards, Wakefield and Barnsley Involvement in Care Quality Commission mental health inspection arrangements
EXECUTIVE DIRECTORS	
Nisreen Booya	Honorary President of the Support to Recovery (Kirklees

Name	Declaration
	mental health charity) Appointed member, Yorkshire and Humber clinical senate, providing independent source of clinical advice for Yorkshire and the Humber Involvement in Care Quality Commission mental health inspection arrangements
Tim Breedon	No interests declared
Alan Davis	No interests declared
Alex Farrell	Spouse is General Practitioner based in Beeston, Leeds
Dawn Stephenson	Voluntary Trustee for Kirklees Active Leisure
OTHER DIRECTORS	
Adrian Berry	No interests declared
Sean Rayner	Member, Independent Monitoring Board for HMP Wealstun Trustee, Barnsley Premier Leisure
Diane Smith	No interests declared
Karen Taylor	Trustee, Barnsley Hospice

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 28 January 2014

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:	Adrian Berry	Director, Forensic Services
	Sean Rayner	District Director, Barnsley and Wakefield
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Diane Smith	Interim Director of Service Innovation and Health Intelligence
	Karen Taylor	District Director, Calderdale, Kirklees and Specialist Services
Guests:	Doug Dale	Members' Council (public, Wakefield)
	Nasim Hasnie	Members' Council (public, Kirklees)
	John Haworth	Members' Council (staff, non-clinical support services)
	Andrew Hill	Members' Council (public, Barnsley)
	Margaret Morgan	Members' Council (appointed, Barnsley Council)
	Bob Mortimer	Members' Council (public, Kirklees)
	Hazel Walker	Members' Council (public, Wakefield)

TB/14/01 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting and the apologies, as above, were noted. He commented on the absence of Karen Taylor (KT), who is undertaking a month's secondment to health services in New Zealand, and Diane Smith (DSm), who has been appointed as Interim Director of Service Innovation and Health Intelligence, on secondment from NHS England.

TB/14/02 Declaration of interests (agenda item 2)

Trust Board considered the following additional declaration.

Name	Declaration
Directors	
Diane Smith	No interests declared

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

TB/14/03 Minutes of and matters arising from the Trust Board meeting held on 17 December 2013 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 17 December 2013 as a true and accurate record of the meeting.

There were two matters arising.

TB/13/63 Welcome, introduction and apologies The Chief Executive (SM) reminded Trust Board of his involvement in the Care Quality Commission's (CQC) inspection regime for mental health trusts as Chair of one of its inspection teams in the first round of visits. Nisreen Booya (NHB) has also just taken part in an inspection, which she commented was a very thorough and robust process. All mental health trusts will be inspected by the end of 2015 and the Trust will be able to learn through the involvement of both SM and NHB for its own inspection. IB commented that their involvement is a real coup for the Trust.

TB/13/67 Specialist services commissioning SM updated Trust Board on the national position in relation to forensic commissioning. Two stakeholder roundtable specialist commissioning review meetings have been arranged, one in Manchester and one in London, through the NHS Confederation and the Foundation Trust Network, with NHS England on 4 March 2014. Both SM and Adrian Berry (ABe) will attend. IB mentioned that this was the main topic of discussion at a recent Foundation Trust Network Mental Health Group roundtable discussion.

TB/14/04 Performance reports month 9 2013/14 (agenda item 4)

TB/14/04a Quality performance report (item 4.1)

Tim Breedon (TB) highlighted a number of issues from the report and, in particular, the following.

- The CQC has visited Fox View, a learning disability unit on the Dewsbury District Hospital site. The informal feedback has been positive although issues relating to recording of information for two individuals were identified. The formal report will follow in due course.
- Fully meeting the target for non-urgent referrals assessed within fourteen days continues to provide a challenge.
- Wakefield is one of ten sites across the country taking part in a national pilot to test a new model to ensure consistent quality of services by placing mental health nurses and other mental health professionals into police stations and courts. The Trust welcomes and supports the initiative although both the commissioner and the Trust were unaware. It could potentially have workforce implications for the Trust. SM commented that this was a good development as liaison and diversion services have historically been commissioned inconsistently.
- In relation to the Implementing Recovery through Organisational Change (ImROC), a more detailed report will be presented to the Clinical Governance and Clinical Safety Committee in relation to the transformation programme and impact on services.
- The Trust has established a Quality Forum and its first area of focus is clinical record keeping and data quality.
- The Trust has developed a standard procedure with clinical managers and team leaders to ensure a consistent approach across the Trust to minimising delayed transfers of care.
- In response to the Francis Report and the Government's response, 'Hard Truths', the Trust has set up a task group to look at the requirements for staffing level reviews and reporting. A summary of the Trust's position will be presented to the Clinical Governance and Clinical Safety Committee. There is limited national guidance for Trusts and it will be left to local determination. The Trust's response to Francis and associated publications is a standing item on the Committee's agenda and is also on the Trust's website.
- A Business Delivery Unit (BDU) governance group review took place in December 2013 and the outcome will inform operational and reporting structures. A report will be presented to the Clinical Governance and Clinical Safety Committee in due course.

- Patient flow arrangements introduced in Kirklees to support the Bed Management Protocol have worked well and will now be implemented across the Trust.

TB also reported on an inquest in December 2013 into the death of a lady in Calderdale early in 2013. The Trust received a Rule 28 Letter from the Coroner following a narrative verdict. This requires the Trust to ensure that there is a signing in/signing out facility for the unit where the deceased was living. The Trust has access to four crisis beds within the accommodation, which are owned and managed by Share (part of Calderdale Council). The Trust is currently preparing a response jointly with Calderdale Council, which will be sent by the required deadline of 5 February 2014. SM added that this matter has been discussed with the Council and, whilst the Trust and the local authority will respond jointly to the Coroner, the case raises two issues, which the Trust will take forward, in relation to:

- joint management arrangements between the Trust and local authorities; and
- commissioning of the crisis model in Calderdale.

IB invited comments from Trust Board on the format and presentation of the quality performance report.

- Bernard Fee (BF) commented that is was a hard read and it appears that information is forced into a proforma. There is also a discrepancy between the ratings and the narrative, which needs more explanation and analysis.
- Peter Aspinall (PA) commented that a management response to changes in performance would be useful. Sean Rayner (SR) assured Trust Board that BDUs scrutinise quality priorities and robust governance processes for review are in place, particularly deteriorating performance.
- BF also commented that this is not an action-oriented report and he would like to see the Trust's response to any issues or red ratings.
- Helen Wollaston (HW) suggested that the report is scrutinised in more detail at the Clinical Governance and Clinical Safety Committee in terms of quality issues in a similar way to workforce issues at the Remuneration and Terms of Service Committee.
- IB added that this is a general information and background report but offers no action and no linkages. He would like to see a focus on exceptions, risks and mitigating action with identified linkages. He would be happy for this report to remain as an information document as an attachment. SM agreed this would be taken back for discussion by the Executive Management Team (EMT).

<u>TB/14/04b Finance report month 9 2013/14 (item 4.2)</u>
Alex Farrell (AF) highlighted the following.

- The forecast is to achieve the plan at the year-end. The Trust is marginally over its surplus target, generated by underspend in a number of areas and provisions offset by risks around CQUINs and opening of beds on Johnson ward.
- The estates revaluation has had an overall negative impact of £1 million provided for in the plan. The positive impact of £1.3 million in relation to Aberford Field is dependent on planning permission, scheduled for February 2014. It will not be realised in this financial year if permission is delayed beyond the end of the financial year. This is a technical issue with no serious regulatory impact.
- A provision of £5.3 million was made to fund re-structuring costs. A further £300,000 has been identified to cover revised reconfiguration costs through in-year budget underspends and review of existing provisions. This adjusted provision allows for an additional £700,000 for 2014/15 taking the total to £2.2 million.
- The recurrent cost improvement programme is currently underperforming by £1.7 million mainly due to unrealised savings from reconfiguration of rehabilitation and recovery services, workforce e-rostering changes and income assumptions in Barnsley. These

have been mitigated through non-recurrent cost improvements in-year. This has an implication for 2014/15, which the EMT is addressing and will be finalised before budgets are set for next year.

The Chair invited comments from Trust Board.

- SM commented that realising efficiency savings through transformation is a challenge, particularly in terms of understanding services and capacity to transform. The Trust's plans have attracted media scrutiny following the Trust Board meeting in December 2013 and this is likely to continue.
- PA asked whether there was a risk in relation to the transformation programme and whether there was a need for expertise and external advice. SM responded that the Trust has, for example, engaged the support of Mental Health Concern to review its rehabilitation and recovery services. This has given a different perspective, identified linkages with other services and provision, such as out-of-area placements, and offered an external view of the scope of the service. This has been supported by discussions with chief officers of local authorities and clinical commissioning groups in terms of risk and benefit sharing arrangements during a time of transformational change.
- BF commented that he welcomed the stance the Trust is taking in relation to transformation and it will provide a good platform to move forward at a faster pace.
- Julie Fox (JF) asked about other areas. SM responded that this is an area for review by the EMT and further assurance will be provided to Trust Board on capacity, both internally and externally, and how this will be secured. JF asked if this would have an impact on timing and SM responded that it would link to business planning for 2014/15.
- In response to a comment from HW about leadership, SM said that health intelligence will provide evidence that the Trust is making a difference and adding value, which is a key role for DSm during her secondment.
- HW also asked about the savings as a result of e-rostering. Alan Davis (AGD) responded that this related to an area put forward by Calderdale and Kirklees BDUs as potential efficiency savings through changes to shift patterns. Assumptions made around savings were valid; however, implementation requires further operational testing.
- PA commented that there are evidently some major challenges for the Trust but the EMT does not have to do this itself from its own resources. He asked again at what point the Trust would seek external support to look at sickness absence. SM concurred but it is incumbent on the EMT to get its approach right and this will be further discussed through the Remuneration and Terms of Service Committee.
- AF commented that £600,000 of the Innovation Fund is set aside to support external, specialist support; however, the Trust needs to have specifications in place to ensure it gets what it needs and the support it wants.

IB summed up the discussion and observations made in that the year-end position for 2013/14 will be achieved with a risk in relation to the estates revaluation; however, the Trust is not as far on its transformational journey as anticipated and achievement of next year's position will be dependent on achieving transformation.

TB/14/04c Annual planning 2014/15 (item 4.3)
AF introduced this item and highlighted the following.

- A new requirement from Monitor for Trust Board to make a declaration of sustainability for two, three and five years has been introduced.
- Contracts with commissioners will be signed by 28 February 2014.
- Monitor has also issued a strategic planning document following an assessment by PWC that the sector is not ready to plan for the challenges ahead. It provides a self-assessment tool for foundation trusts to assess their position and areas for improvement or development work.

AF went on to explain the assumptions made in planning for the next five years.

IB invited comments from Trust Board.

- PA asked about the impact of the challenge from the Trust's external auditors. AF responded that Deloitte presented an action plan at the Audit Committee, which set out the risks to reporting in the financial accounts. These relate to:

  - Agresso patching;
  - implementation of payment by results;
  - implementation of the nil assurance report in respect of non-pay purchasing control;
  - revenue recognition (mandated risk);
  - accounting for the acquisition of Barnsley estate;
  - valuation of Trust estate;
  - mandatory override controls (mandated risk);
  - responding to Monitor's report on foundation trust strategic planning.

  The two mandated risks are not considered to be a risk and strategic planning will be a key area for review.
- PA added that Deloitte sees any proposed efficiency savings over 3% as a challenge and will, therefore, give close scrutiny to the Trust's plans to achieve 5.5%. AF responded that the Trust's plan is consistent with Monitor's requirements.
- Jonathan Jones (JJ) asked where the Trust was in relation to a co-ordinated approach to business development through securing commercial/marketing expertise. AF responded that two senior posts have been identified in relation to marketing and commercial development, and these will be recruited in the 2014/15 financial year.
- IB asked that all members of Trust Board are involved in contributing to the formulation of the plan and the underpinning analysis.
- He added that Trust Board will need to carefully consider its response to the declaration of sustainability and to provide a measured and considered explanation for its declaration.
- SM commented that alignment with partners and partnerships are key to sustainability and this is an area the Trust must foster and develop.
- BF suggested a more aggressive approach to reviewing and revising the infrastructure and the speed with which the Trust does this.

<u>TB/14/04d Human resources strategic report month 9 2013/14 (item 4.4)</u>
In introducing the report, AGD commented that fundamental to the Trust's sustainability is its resilience in a time of unprecedented change. This presents a complex challenge.

<u>Sickness absence</u>
In response to an issue raised at December's meeting, an analysis of sickness levels in Barnsley has shown no correlation between sickness absence and the level of vacancies. AGD also assured Trust Board that robust management action is in place to address sickness absence levels and to manage use of bank, agency and overtime. SR commented that management of the short-term sickness absences has significantly reduced the rate; however, there is significant long-term sickness absence in Barnsley, which is impacting on rates. ABe added that sickness continues to be a priority and the medium secure service is showing a lower rate than previously whilst it is taking longer to manifest improvements in low secure.

JF commented that stress-related sickness is the biggest contributor to absence. AGD responded that this will not necessarily be work-related. There is strong support in terms of wellbeing and occupational health within the Trust, demonstrated in the wellbeing survey, and the impact on health and wellbeing by leadership and management. The wellbeing

survey is able to drill down to individual team level to see where action needs to focus and where further management action is needed. Other areas, such as access to support from the Big White Wall, are being developed. The occupational health service will concentrate on stress in 2014/15 and wellbeing support to proactively prevent staff from absence.

HW asked about the trajectory for improvement. AGD responded that it will depend on the service; however, the Trust can learn from areas where improvements have been made.

JJ asked whether the Trust was expecting an increase in absence when 2014/15 gets tougher. AGD agreed that the coming year would probably see an increase; however, HR Business Partners are part of the transformation programme and wellbeing and resilience will be built into the change management support for staff.

PA asked whether there was any benchmarking of the Trust's occupational health service. AGD responded that the service is run in conjunction with Leeds Partnerships NHS Foundation Trust and, therefore, the Trust is able to prioritise where the service's focus should be, such as musculo-skeletal and stress. In 2014/15, the service will introduce proactive physical screening of staff, and take account of national guidance for a good occupational health service and best practice.

PA asked how the Trust's service compares with the private sector, particularly potential competitors. AGD responded that staff within the service come from the private sector and the service looks for areas to improve and offer best practice.

BF commented that the Trust has made good progress on absence; however, this relates to a small amount of money. He understands the detail of sickness absence but not that of the cost improvement programme. He would like the same level of detail to enable him to scrutinise efficiencies in the same amount of detail, which is just as important, if not more so, for Trust Board to understand and for the Trust's future.

BF also commented that achievement of the appraisal target was commendable but the focus should be on quality not quantity, therefore, the exercise needs to be seen as more than a tick box process.

JF commented that it is admirable that the Trust is developing a values-based recruitment process but this does not include consultants. She would like to see this extended as these are senior posts.

TB/14/04e Service user experience report (item 4.5)

Dawn Stephenson (DS) introduced this item and comments from Trust Board were invited.

- HW commented that she would like to see more on the lessons learned and the 'so what' in response to feedback. SM added that he would like to see further analysis of the effectiveness of what the Trust does.
- IB asked what Barnsley BDU was doing to attract the number of compliments, particularly when reviewed against forensic services. It was generally agreed that the concept of 'choice' was affecting the figures. Also, people tend to complain in writing but compliment anecdotally (and only written compliments are included in the report currently).
- IB asked whether there was anything services could learn from each other in relation to comments from staff.
- HW asked whether the Trust captures other types of feedback. DS responded that mechanisms have been established and HW asked for this to be included in the report in future. SM added that this should also include dialogue groups.

It was RESOLVED to NOTE the revised arrangements for reporting 'What Matters' and for a formal review of customer services feedback on a quarterly basis.

TB/14/04f Exception reports and action plans – Trust planned visit programme (item 4.6(i))
TB assured Trust Board that the Trust would reflect the CQC 'themes' in the new inspection regime but on a more focussed, service basis; however, it would be difficult for the Trust to replicate the CQC visit arrangements. IB commented that he would keen to see feedback from the national CQC visits to see if anything can be learned and replicated. JF also asked that future planned visits link to CQC visits and follow up visits so services do not receive multiple visits.

HW commented that the visits are an important element of assurance to Board members and demonstrates leadership and visibility of the Board. It is not just about the CQC and the visits are an important principle that she would like to see continue.

AGD suggested that a risk profile of wards/units would be useful to identify areas to focus on, such as seclusion rooms visited in the next round of visits or areas with high sickness to be probed.

SM commented that the CQC's inspection will lead to a rating for an organisation, which will provide assurance for the Trust in terms of quality of services. As more intelligence about the CQC's national programme emerges, the Trust can undertake a self-assessment of its own services.

It was RESOLVED to NOTE the report and SUPPORT the future visits proposal.

TB/14/04g Exception reports and action plans – Update on seclusion rooms upgrade programme (item 4.6(ii))
Trust Board noted that the CQC has accepted the Trust's action plan in relation to the seclusion units' upgrade and site visits will be undertaken in conjunction with the CQC. ABe confirmed that the refurbishment work has been phased to ensure it meets service needs and to reduce clinical pressures.

It was RESOLVED to NOTE progress.

TB/14/04h Exception reports and action plans – National service user surveys (item 4.6(iii))
SM commented that it was unacceptable for a transformational organisation not to be getting the basics right and he would like to see a public reinforcement of the accountability for professional standards. JF commented that there has to be a level of understanding of a care plan not just whether an individual has been given one. BF asked whether service users are aware of what constitutes a care plan. JJ asked whether this was not also a Monitor target that the Trust reports on. AF responded that it is and represents a mis-match between practice recorded on RiO and service user perception. IB asked that a report comes back to Trust Board on action the Trust has taken to address this and to re-ask service users in the interim. BF suggested the Trust could also learn from best practice. It was agreed to receive a further report at the end of quarter 1 2014/15.

HW also commented that she would like to see this included in the values-based appraisal in terms of how behaviours are realised.

It was RESOLVED to NOTE the report and to RECEIVE a further paper in July 2014.

TB/14/05 Review of Standing Financial Instructions (agenda item 5)

AF confirmed that the Chief Executive had commissioned a review of the Quality Academy, which will feed into the review of the Scheme of Delegation, therefore, there will be a delay in presentation to Trust Board.

It was RESOLVED to APPROVE the revised Standing Financial Instructions.

TB/14/06 Trust Board self-certification – Monitor quarter 3 return 2013/14 (agenda item 6)

PA informed Trust Board that, at the Audit Committee on 21 January 2014, KPMG reported on the initial outcome of its review of financial management, which included a review of the recommendations from the procurement (non-pay purchasing) audit. All actions were complete with one exception in relation to outsourcing goods received, which will be the subject of an options appraisal in conjunction with other support services to ensure the goods received process in place is robust.

It was RESOLVED to APPROVE the exception report to Monitor.

TB/14/07 Assurance framework and organisational risk register quarter 3 2013/14 (agenda item 7)

BF asked whether the cost improvement programme should be a specific risk on the register. SM responded that it would be covered by other risks on the register, particularly the operational detail linked to the transformation programme.

It was RESOLVED to NOTE the assurances provides, NOTE gaps in assurance identified, and NOTE the key risks.

TB/14/08 Date and time of next meeting (agenda item 8)

The next meeting of Trust Board will be held on Tuesday 25 March 2014 in the Manor room, 5th floor, F Mill, Dean Clough, Halifax.

Signed …… Date ……

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Audit Committee held on 21 January 2014

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
Apologies:	Members	
	Jonathan Jones	Non-Executive Director
	Others	
	Tim Cutler	Head of Internal Audit, KPMG
	Paul Hewitson	Senior Audit Manager, Deloitte
In attendance:	Robert Adamson	Head of Finance
	Tim Breedon	Director of Nursing, Clinical Governance and Safety (to item 3)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Tony Cooper	Head of Procurement
	Mark Dalton	Manager, KPMG
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Clare Partridge	Director, KPMG
	Karen Sharrocks	Senior Manager/LCFS, KPMG
	Michael Smith	Publicly elected Governor, Calderdale
	Dawn Stephenson	Director of Corporate Development
	Paul Thomson	Partner, Deloitte
	Robert Toole	Interim Deputy Director of Finance

AC/14/01 Welcome, introduction and apologies (agenda item 1)

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

AC/14/02 Minutes of the meeting held on 18 October 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 18 October 2013 as a true and accurate record of the meeting.

AC/14/03 Matters arising from the meeting held on 18 October 2013 (agenda item 3)

There were six matters arising.

AC/13/26 Internal audit progress report (clinical audit) (agenda item 3.1)

Tim Breedon (TB), as lead Director, provided assurance to the Committee in relation to progress against the recommendations of the internal audit undertaken by West Yorkshire Audit Consortium in February 2012 and a follow up by KPMG in October 2012.

1. Strategic use of clinical audit – clinical audit activity has been aligned with the priorities set out in the Quality Improvement Strategy to ensure they reflect and support the quality priorities for the Trust. As part of this process, the leadership and structure of the Clinical Governance Support Team (CGST) has been reviewed as well as the membership of the Steering Group. Outcomes of audits are reported to the Clinical Governance and Clinical Safety Committee and tracked.
2. Increased automation and 'self-service' approach to clinical audit – the suggestions made by KPMG to make the process more efficient have been taken on board, including development of standard documentation, and online availability. An e-learning package has also been developed to support staff outside of the CGST.

3. Nominated clinical audit liaison in each Business Delivery Unit – nominations from BDUs have been sought and the CGST attends BDU governance meetings. Surgeries have also been held to inform BDUs of the work of clinical audit.
4. Specialisation of the CGST – the work plan for clinical audit has been re-designed to reflect priorities and scoped to assess the level of team involvement.
5. Reporting of clinical audit outcomes – each audit and its outcomes are 'RAG' rated and findings in reports made clearer. Spot check audits are also undertaken to support outcomes.

Bernard Fee (BF) asked what the Trust had learned from clinical audit in the last year and how audit activity had enabled and supported improvement. TB responded that the processes in place now will enable the Trust to articulate this at the year-end. Alex Farrell (AF) suggested an annual report on a similar basis to the report to the Committee on the Innovation Fund. BF added that he would like to see KPMG use the outcome of clinical audits to identify potential areas of risk for the Trust and identify where more work is needed in order to facilitate improvement. Clare Partridge (CP) confirmed that follow up of the outcomes of clinical audit and how actions are taken forward would be part of KPMG's audit plan for the coming year.

AC/13/52 Audit Committee self-assessment – training

AF will agree a proposal with KPMG, in consultation with Deloitte, for presentation to the next meeting. There was a general view that any sessions arranged should be taken prior to the formal meeting.

Action: Alex Farrell

AC/13/54 Clinical record keeping (agenda item 3.2)

TB highlighted a number of improvement activities.

- A Data Quality Steering Group has been established, chaired by the Director of Nursing. The focus of the Group is to align data collection with the Trust's quality priorities. There is a plan in place for each BDU to address data quality issues and progress can be seen.
- Key standards for record keeping have been developed and will form the basis of a record keeping audit.
- Links have been made within BDUs between currency development leads and Practice Governance Coaches.
- The Quality Forum in December clearly articulated the Trust's requirements in terms of data quality.
- Local dashboards have been developed for teams to understand their position in relation to data quality.

AF added that this has been an ongoing issue for the Trust for some time and is a shared responsibility across the Executive Management Team (EMT). A conscious decision was made for the Director of Nursing to chair the Steering Group with a clear articulation of responsibility around:

- professional standards, what and where information should be recorded, which is the responsibility of the Director of Nursing and Medical Director;
- the system to capture and report data, which is the responsibility of the Deputy Chief Executive/Director of Finance; and
- communication of both, which is the responsibility of BDU Directors.

PA asked what evidence there was that communication is in place and effective. TB responded that the message is reinforced through BDU governance groups and the annual planning process down to team level. BF was concerned that the Trust is not embracing technology quickly enough to make thing easier for staff, such as voice recognition. AF

responded that this is reflected in the IM&T Strategy and implementation plan but it is important that technology adds value. It must be a substitution not an addition to what is already in place. PA commented that, as Chair of the IM&T Forum, it is important that IT is fully engaged in the transformation agenda to the benefit and support of services.

AC/13/63 Creative Minds
An update on the organisational form for Creative Minds will be presented to Trust Board, in its role as Trustee for charitable funds, on 28 January 2014.

AC/13/66 Wakefield Council internal audit
BDU Directors have been asked if they are aware of similar activity in other local authority areas. AF suggested raising through other networks, such as Directors of Finance, in relation to integrated working and whether there are any plans to audit such work. This will also be discussed with KPMG as part of the plan for 2014/15.

Action: Alex Farrell

AC/14/04 Internal audit review of Mental Health Act assessments
AF explained that the review followed a concern raised by the Medical Director on the level of reimbursement to middle grade doctors for Mental Health Act assessments. As a result, the review was instigated and terms of reference developed to understand the practice, review data on process and resources, and provide recommendations in relation to standards and improvements. Karen Sharrocks (KS) took the Committee through the main recommendations and findings. A separate independent external piece of work has been commissioned to look more closely at practice, which this report supports.

BF was concerned about the effect on the clinical care of service users as a result. AF confirmed this is what the second piece of work will look at.

PA asked how payments could get through to payroll without standard approval mechanisms. KS responded that the processes and authorisation in place for claiming are historical and differ across BDUs. AF confirmed that, if payroll receives the appropriate form with an appropriate signature, it would not question whether to make a payment. It was agreed to clarify in what circumstances the Trust makes itemised payments to individuals through payroll and what approval mechanism are in place for these at the next meeting.

Action: Alex Farrell

TB commented that local authorities also have a responsibility for assessments under the Mental Health Act through Mental Health Act leads and it is important that the Trust shares the report with both local authorities and commissioners.

AC/14/05 Transforming Community Services – benefits realisation (agenda item 4)

AF explained that the original business case had been assessed against the latest strategic planning guidance from Monitor. A number of areas were identified where the Trust could make improvements in any future transaction. These relate to:

- integrated physical and mental health services under one management structure, which can be applied to other districts;
- the benefit of using technology to support services;
- the potential for health and wellbeing services to shift dependency on statutory services.

Paul Thomson (PT) commented that it was a common experience for foundation trusts that strategic business realisation was poor under TCS with the focus on the first 100-days and the transaction. He was pleased, therefore, to see this report at the Audit Committee. BF added that it was generally felt during the transaction process that the Trust was meeting Monitor timescales and requirements, which might not have been right for the Trust and which might have been a distraction from areas where the Trust should have focused more attention. His challenge to the Trust is to now link transformation to the financial performance of the organisation. As an organisation, the Trust has a very clear plan for transformation but it is not clear that this links to improving financial performance and activity. CP commented that this would be supported by two pieces of internal audit work on transformation, and leadership and management arrangements.

AC/14/06 External audit plan 2013/14 and fee proposal (agenda item 5)

PT outlined external audit responsibilities and confirmed that Monitor has confirmed there will be no changes to the scope of Quality Accounts for 2013/14. He also took the Committee through the key audit risks, the rationale for identifying these risks and the audit approach. These relate to:

- Agressso patching;
- implementation of payment by results;
- implementation of the nil assurance report in respect of non-pay purchasing control;
- revenue recognition (mandated risk);
- accounting for the acquisition of Barnsley estate;
- valuation of Trust estate;
- mandatory override controls (mandated risk);
- responding to Monitor's report on foundation trust strategic planning.

A key risk area will be the alignment by Monitor of foundation trusts' strategic plans with clinical commissioning group strategic planning and the re-design of pathways across local health economies to deliver further efficiency savings whilst improving quality. Deloitte will want to see how the Trust has addressed this and has worked within its local health economy to address challenges. AF responded that there is recognition nationally of the parity of esteem for mental health and community services, and the Trust must use this to best effect.

PT also highlighted Monitor's revised Code of Governance for implementation from 1 January 2014. For the Committee, the main issues are the requirement for the annual report to cover significant issues and how these were addressed by the Audit Committee, audit remuneration and policy for external audit, and how the Committee has addressed external audit performance. A paper from Deloitte will be presented to the next Committee.

Action: Deloitte

In the annual reporting manual, there are two main changes in relation to:

- losses and special payments guidance and a new responsibility for Deloitte to report to Monitor and the National Audit Office if approval processes are not followed; and
- guidance on charitable funds consolidation.

The Committee noted the fee proposal and the reduction in the fee to reflect the agreement as part of the extension of the audit period. It was noted that the fee is also set for the year ending 31 March 2015. **It was RESOLVED to APPROVE the fees for external audit for 2014/15.**

Michael Smith (MS) commented that he would like to see an explanation at the Members' Council on the value the governing body will get from strategic and tactical IT procurement support. PT agreed to provide clarity.

Action: Deloitte

AC/14/07 Agreement of annual accounts timetable and plans (agenda item 6)

It was RESOLVED to APPROVE the annual accounts timetable and plans. CP asked whether there were timely approval processes in place with regard to Monitor's Code of Governance. Dawn Stephenson (DS) confirmed there were.

AC/14/08 Review of Standing Financial Instructions (agenda item 7)

PA asked how the Trust could be sure that all decision-makers will comply. Robert Toole (RT) responded that this is managed through the EMT through the Scheme of Delegation and it is Directors' responsibility to ensure senior managers adhere to SFIs and delegated limits of approval. This will be done through individual managers signing-off their budgets. AF added that individuals' levels of authority are delegated through the Scheme of Delegation, which sets out individual roles and responsibilities. This will be communicated across the Trust with support from the communications team following presentation to Trust Board in March 2014 for approval.

Tony Cooper (TCo) was asked for his view of the delegated limits. He responded that these were lower than neighbouring Trusts. Agresso training for staff reinforces delegated limits and all staff who use the system are required to attend. AF commented that any changes to delegated limits must be based on evidence not anecdote. The greatest materiality is in facilities and estates and there is a concerted move to get arrangements onto a contract basis. There would, therefore, be less need for individual purchases of large amounts. Given the no assurance audit opinion, she did not think this was the time to start raising limits. This was supported by KPMG. KS added that the SFIs set out very clearly the implications of staff not adhering to SFIs and this needs to be made clear in communication to staff.

It was RESOLVED to APPROVE the revised Standing Financial Instructions and RECOMMEND approval to Trust Board at its January meeting.

AC/14/09 Declaration of interests process and registers for Trust Board, the Members' Council and staff (agenda item 9)

BF commented that this was a good piece of work although he was slightly concerned about the scale of what could be declared. It needs to be fully supported across the Trust. Whilst it is the overarching responsibility of the Director of Finance for staff, other Directors have a responsibility to ensure staff comply.

It was RESOLVED to NOTE the report and APPROVE the proposal to review the staff register of interests on behalf of Trust Board on an annual basis, starting in July 2014, reporting to Trust Board in September each year.

AC/14/10 Foundation Trust financial forward plan benchmarking (agenda item 9)

The report was noted and will be used to inform strategic planning.

AC/14/11 Audit Committee annual report (agenda item 10)

PA commented that he had raised three points in relation to:

- closely defining the EMT and internal audit relationships;
- the discounted audit fee from Deloitte;
- inclusion of exchequer funds within charitable funds in relation to Creative Minds.

It was RESOLVED to APPROVE the first draft of the Committee's annual report. No changes were made to the terms of reference and the work plan was noted. The outcome of the self-assessment will be included in the final draft of the report in April 2014.

AC/14/12 Service line reporting, currency development and reference costs (agenda item 11)

BF commented that he would like to see a temperature check of the implementation and use of data. AF responded that she could provide assurance to the Committee; for example, performance reports to Trust Board include metrics from this work. BF still had no evidence that this is embraced and the information being used to inform decisions within services. Currency management and service line reporting are two areas to be reviewed by KPMG and will be reported to the next meeting. This should provide a clearer view of the position and assurance to the Committee. It was also confirmed that progress is reviewed by performance EMT.

PA commented that, at some point, the information has to be used as a tool for improvement not 'imposed' on teams and units. RT responded that data needs to be accepted as good clinical practice and tested through clinical audit. AF added that Trust Board has a big part to play in establishing a culture where this information is seen as a key part of good clinical practice. There are areas within the Trust where this culture does not exist, it takes time to change and is dependent on the leadership and management arrangements in place within the Trust. KPMG was confident that these issues would come through the various audits reported to the next meeting.

AC/14/13 Treasury management update (agenda item 12)

AF confirmed there was no anticipation of a change in approach by Monitor. The report was noted.

AC/14/14 Internal audit progress report (agenda item 13)

CP commented on the review with management of the methodology for agreeing the scope and work plan for 2014/15, which was noted by the Committee.

Mark Dalton (MD) took the Committee through the three reports completed and presented to the Committee. These related to risk management and board assurance framework, the Information Governance Toolkit, and infection prevention and control. All were given a moderate assurance opinion. There were no significant issues arising from work currently in progress.

He also alerted the Committee to the review of financial management, which includes a review of purchasing and procurement. Although the report is still in draft and has to be discussed with management, he was comfortable and content with the progress made against the recommendations from the procurement (non-pay purchasing) audit, therefore, KPMG was currently anticipating a substantial assurance opinion with no significant risks to report. The review looked at:

- progress against recommendations
- testing of controls;
- review of large transactions.

In terms of the Head of Internal Audit Opinion, CP confirmed that a substantial assurance opinion for core controls of financial management would support the Opinion. Lower assurance levels given by KPMG relate to areas where the Trust has asked for a review with a view to identifying areas for improvement and, therefore, wholly consistent with areas where the Trust has identified weaknesses. She would, therefore, expect a clean Head of Audit Opinion.

The Recommendation Tracker Report was noted. In relation to health records management, TB explained that there was confusion over the officer lead internally, which has now been resolved. The lesson for the Trust is that action needs to be assigned to the correct individual.

In relation to the Section 17 leave audit, he confirmed that it will be repeated in February 2014 and the action plan will be monitored through the Mental Health Act Committee and Data Quality Steering Group.

The report shows that more recommendations are being implemented and evidence provided by the due date. Agreement of evidence that KPMG is expecting will also ease the process with follow up. RT commented that the outstanding recommendation for procurement does not relate to a compliance issue but a proposal for the Trust to consider. An options appraisal is underway.

The Committee also noted the technical update.

AC/14/15 Counter fraud progress report (agenda item 14)

AC/14/15a Progress report (agenda item 14.1)

KS outlined the key highlights of the report, in particular raising awareness and the update on investigations.

In relation to the issue around children's and adolescents' mental health services data, DS updated that the member of staff who raised this issue has not stood by her initial claim. It appears that the issues are related to the management of data systems and lack of staff confidence with the systems in place with the former provider. The point made was that data pulled together for commissioners from IT systems did not reflect real activity and the pressures clinical staff were under were not responded to by managers. To support their concerns, staff developed manual collection of data, which was ignored.

The outcome of the NHS Protect review was noted. The recommendations are part of the audit process and will be included in the 2014/15 work plan.

AC/14/15b Corruption and Fraud Policy (agenda item 14.2)

DS and AF will agree how this should be disseminated within the organisation to ensure that staff are aware. KS was happy to share best practice with the Trust.

Action: Dawn Stephenson/Alex Farrell/Karen Sharrocks

AC/14/16 Procurement report (agenda item 15)

TCo took the Committee through the report. At April's meeting, he will present a comparison of waivers with last year. The report was noted.

BF queried three waivers in relation to compliments cards, insurance and Shropshire Youth Health Champions. TCo explained that the cards related to long-service award vouchers, insurance includes insurance for staff on the car salary sacrifice scheme and that the Shropshire contract was a project through Altogether Better.

AC/14/17 Losses and special payments report (agenda item 16)

The report was noted. The Trust will ensure that guidance in the annual reporting manual is considered and any implications drawn to the Committee's attention.

AC/14/18 Date of next meeting (agenda item 17)

The next meeting will be held on Tuesday 8 April 2014 at 14:00 in training room 5, Learning and Development Centre, Fieldhead, Wakefield.

AC/14/19 Any other business (agenda item 18)

AC/14/19a Estates revaluation (agenda item 18.1)

RT explained the accounting treatment of Aberford Field if planning permission is not granted by the end of the financial year. Deloitte is supporting the Trust and the matter will be reported to Trust Board on 28 January 2014.

Minutes of Clinical Governance and Clinical Safety Committee held on 11 February 2014

Present:	Bernard Fee	Non-Executive Director
	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust (Chair)
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
Apologies:	Dawn Stephenson	Director of Corporate Development
In attendance:	Peter Aspinall	Non-Executive Director
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance

CG/14/01 Welcome, introduction and apologies (agenda item 1)

The Chair (HW) welcomed everyone to the meeting and the apology was noted. The Committee noted that Peter Aspinall (PA) was attending in his capacity as Chair of the Audit Committee.

CG/14/02 Minutes of the previous meeting held on 3 December 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 3 December 2013.

CG/14/03 Matters arising (agenda item 3)

There were three matters arising.

CG/12/34 Update on progress to devolve pharmacy services to BDUs (agenda item 3.1)

Nisreen Booya (NHB) reported that a revised job description has been finalised for the Chief Pharmacist and the outcome of the Agenda for Change process should be known by 5 March 2014. The post will then be advertised. She confirmed that pharmacy services are managed within specialist services (Director lead Karen Taylor, BDU Director, Calderdale and Kirklees) in Calderdale, Kirklees and Wakefield. In Barnsley, the service is contracted out to Lloyds Pharmacy and is managed within Barnsley BDU. The plan is to devolve all pharmacy services to BDUs under specialist services. The Chief Pharmacist will be accountable to the Medical Director but managed within specialist services.

The recommendations from the internal audit are being taken forward by the Acting Chief Pharmacist in conjunction with the Head of Specialist Services. Julie Fox (JF) asked for an update on all recommendations in the internal audit report at the next meeting. Bernard Fee (BF) agreed that this would be timely as he would like assurance on progress as he was currently unsure that the recommendations, particularly around the security issues raised in the Dales, had been addressed.

Action: Nisreen Booya

HW also asked that the Pharmacy Strategy is presented to the Committee when it has been developed.

Action: Nisreen Booya

Alan Davis (AGD) alerted the Committee to a national audit tool issued by the Security Management Service for the security of medicines. The Trust will undertake a self-assessment with a report or update to the next meeting.

Action: Alan Davis/Tim Breedon

AC/13/85 Process for learning lessons from the Local Government Ombudsman's report (agenda item 3.2)

Tim Breedon (TB) introduced this item for Dawn Stephenson (DS). A joint action plan was developed with the local authority in relation to:

- ensuring family members are involved in care;
- developing a joint protocol for the handling of complaints where these are handled jointly with the Council;
- developing a process to assess prescriptions for Aricept;
- making financial redress as directed by the Ombudsman.

AC/13/91 Update on meeting with MIND regarding prone restraint (agenda item 3.3)

This item was deferred to the next meeting in as the meeting with MIND was postponed to March.

Action: Tim Breedon

CG/14/04 Children's services (agenda item 4)

The Committee did not feel that the paper presented gave sufficient assurance on areas of risk. HW asked to receive an outline of the overall strategy and vision both for children's services and children's and adolescents' mental health services (CAMHS), the minimum level of service deemed to be safe and, if not in place, the mitigating action the Trust will take. TB added that this should also include how services meet the Trust's quality priorities and outline mitigating action against risks. BF asked whether this should form part of a wider strategic discussion at Trust Board on what services the Trust wants to provide now and in the future, and the strategic approach to achieving this.

The Committee asked for a presentation in April to provide assurance to the Committee that risk is being managed. BF asked if TB could circulate an update on children's services in the meantime to provide assurance on areas where the Trust could be vulnerable, mitigating action and next steps. It was suggested that either Sean Rayner or Karen Taylor attends the meeting in April. The Committee asked for an update on the position at Greenacre School before the next Committee as it was not fully assured on the action the Trust has in place.

Action: Tim Breedon to follow up

CG/14/05 Quality Accounts 2013/14 (agenda item 5)

Monitor has confirmed that foundation trusts are required to commission an external audit of two out of three mandated items:

- gatekept admissions;
- seven-day follow up;
- delayed transfers of care.

As significant work has taken place to provide a framework for accurate recording of delayed transfers of care, the audit will focus on the first two items. The locally mandated item will be agreed by the Members' Council Quality Group on 12 March 2014 following agreement by the Members' Council to delegate authority to the Group to agree this indicator.

The format of the report will reflect the comments made by Deloitte and will refine the 2012/13 report. HW asked that items rated 'red' are accompanied by a robust explanation and mitigating action.

BF commented that that the Quality Accounts should be a true reflection of the organisation and form a document that encourages people to read and take note of the information. AGD suggested a very brief, accessible summary to accompany the final document, which could be used in areas such as recruitment.

AGD also alerted the Committee to the reporting of the Friends and Family test for staff every quarter from 1 April 2014. Further work is needed on how this will be gathered and reported. This year's national staff survey will be used as a benchmark for 2013/14.

CG/14/06 Serious incidents quarterly report (agenda item 6)

TB reminded the Committee that the serious incidents' figures now include pressure ulcers and information governance incidents. Without these incidents, the figure would be approximately 34, which would be within tolerance of last year's figure. He confirmed that this issue is understood by CCG Quality Boards.

The Committee questioned the suspected suicides figure in table 4 (page 11) and asked that, for future reports, this table is incorporated into the average suicide rates table. BF asked what the Trust is doing to ensure the apparent upward year-on-year trend is monitored and reviewed appropriately and the trend does not mask an underlying issue. HW asked that this analysis is included in the serious incidents annual report.

AGD commented that a considerable sum of money was invested in serious incidents investigators. There is a need to assess the impact of the investigators in ensuring lessons are learned and learning is transferred across BDUs and services particularly in terms of any recurring recommendations and issues arising from serious incidents.

NHB commented that she still has concerns about the quality of serious incident reports and the objectivity of reporting and recommendations. Although improvements have been seen, there is scope for further improvement and development.

BF commented that he took no assurance from the report on pressure ulcers. TB responded that it provided a good explanation for attributable/non-attributable incidents but did not provide any information on mitigating action when incidents are avoidable and to prevent deterioration when they do occur. TB was asked to feedback to the appropriate BDU Director that the Committee would like a further explanation of the action being taken to ensure the Trust does all it can to prevent the deterioration of pressure sores and best possible care to those affected. This will be included in the next quarterly report.

Action: Tim Breedon

CG/14/07 Health and safety update (agenda item 7)

AGD introduced the report and made the following comments.

- Staff side health and safety representatives have expressed some concern regarding a perceived downgrading of incidents in relation to violence against staff by patients following a management review. AGD and TB will review the incidents on DATIX and the grading levels. AGD will report back to the Health and Safety TAG in March.

- Health and safety objectives for 2014/15 will include integration with other areas such as managing aggression and violence and infection prevention and control. The objectives will be presented to the Committee in April 2014.

Action: Alan Davis

- A risk-based audit process has been developed and the outcome will be incorporated in the Health and Safety Annual Report.

CG/14/08 Sub-groups (agenda item 8)

The following issues were highlighted.

Incident Review Panel

- Action plans arising from the management of the incident review process will be monitored through BDU governance processes.
- The Clinical Reference Group has been established and its first meeting will be held on 14 February 2014.
- Mike Ventriss has been appointed as Associate Director of Patient Safety.

Drugs and therapeutics

- Membership of the TAG and its sub-groups have been reviewed. The number of sub-groups has reduced from eleven to five, with the majority moving into BDUs to ensure operational ownership.
- The annual awayday has taken place and a revised Medicines Management Strategy was approved by EMT on 6 February 2014. As part of the review of the Strategy, it was agreed to develop a separate Pharmacy Strategy.

Health and safety

Taken under agenda item 7.

Infection Prevention and Control

- In the first nine months of the year, there have been seven C-Difficile incidents reported in Barnsley; therefore, the target of eight could be breached. Root cause analysis processes have established that six of the incidents were deemed to be unavoidable with the analysis of the seventh incident to be completed.
- An internal audit of infection prevention and control arrangements has attracted a moderate assurance opinion. The Committee will formally receive the report in April 2014 and the recommendations will be incorporated into the infection prevention and control annual plan for 2014/15.

Action: Tim Breedon

Safeguarding

- There are ongoing investigation processes into three homicides (in Barnsley, Calderdale and Kirklees).
- The serious case review in Kirklees may have implications for the Trust in terms of litigation and reputation management and is subject to close management through communications.
- The Prevent agenda mandates three hours of training for all NHS staff to raise awareness of the risk of radicalisation of young people. The Trust will assess how best to implement this as part of existing training arrangements.
- The Committee noted the increased safeguarding activity, particularly in Barnsley and Calderdale as a result of the improvement notices issued to both local authorities.

Managing aggression and violence

- Significant work has been undertaken in relation to extra care facilities as a result of revised guidance on the use of the facility in the Horizon Centre.

CG/14/09 Committee annual report, review of terms of reference and annual work programme, and self-assessment (agenda item 9)

The Committee generally agreed that the structure of the Committee and the content of its meetings is right but an operational perspective is missing; however, the Committee agreed that it must ensure individuals attend for a purpose so further clarity on the content and purpose of agenda items will be needed. It was agreed to invite medical staff and Practice Governance Coaches to attend as a learning and engagement exercise.

Action: Tim Breedon/Nisreen Booya

BF commented that he would like to see a shift in the focus of the Committee to establish processes to shape and influence the organisation's direction and approach and to focus on the end user in a way other Committees do not. NHB commented that quality and safety must drive the Committee's agenda. HW added that there must, therefore, be a balance of forward-looking items with performance and risk related issues.

AGD commented that a key issue for the Committee is to ensure the transfer of learning across the Trust. TB added that the Committee needs to be assured that there are appropriate assurance mechanisms in place in relation to devolvement of governance arrangements to BDUs and clarity on lines of accountability. NHB responded that interpretation of the devolvement of governance arrangements to BDUs and local autonomy has already been highlighted as a risk by the Committee. BF felt that the biggest risk for the Trust is clarity on accountability for the delivery of services and accountability for designing a consistent approach across the Trust. Without clarification, transformation will be delayed. AGD added that, if services are delivered in different ways, the Trust needs to ensure it understands why and has a rationale for differential models of services. Openness and transparency is key to a devolved structure. BF responded that the Trust could not, however, start from a position that services are able to provide different services; service models must start from a consistent base and a rationale and justification for differences then established. PA asked what the role of the Quality Academy would be as his understanding was that it is the 'glue' that holds this together.

The Committee agreed that its focus for the coming year would be:

- a stronger focus on the quality of Trust services looking in more detail at how each of the quality priorities is being implemented;
- to seek assurance that learning from best practice and from serious incidents is transferred across the Trust given the devolved management arrangements; and
- in a climate of increased risk presented by the cost improvement challenge, stronger operational input to the Committee is required to provide assurance to Trust Board that the clinical risks are being effectively managed.

It was agreed to include a summary of the discussion in section 6 of the annual report.

It was RESOLVED to APPROVE the first draft of the Committee's annual report. No changes were made to the terms of reference and a number of changes were agreed to the work programme, which will be incorporated in the final version. The outcome of the self-assessment will be included in the final draft of the report in April 2014.

Action: Bernie Cherriman-Sykes (for the Chair)

CG/14/10 Use of Bed Management Protocol (agenda item 10)

TB reminded the Committee that the Protocol was introduced as a result of a number of incidents at the Dales. Implementation was reviewed in December 2013 and the following actions agreed.

- Each BDU will develop a contingency plan and early warning system for independent review.
- An audit of the 'protected beds' arrangements will be completed by the end of February 2014.
- There will be a review of the use of RiO and how all beds across the Trust are recorded.
- Further work is needed to address cultural issues around bed management across the Trust.
- A further review will be undertaken at the end of January 2014 and the outcome and any further actions required taken into EMT.
- The review of the Protocol will be completed by 27 February 2014.

It was noted that bed management incidents reported where no bed is available have reduced since implementation of the Protocol with three reported in November 2013, one in December 2013 and none in January 2014.

AGD commented that, as a Director on-call, he still perceives there are operational issues with management of bed pressures and how contingency arrangements are developed. It was agreed to invite Sean Rayner to attend the next meeting and the Committee asked for a report on the numbers of incidents, how often Trust beds are full, arrangements to mitigate and manage these instances, and future Trust action, which was what was requested for this meeting. The Committee could not feel fully assured about the implementation of the process in place without this information.

Action: Tim Breedon to agree with BDU Directors

CG/14/11 Quality Impact Assessments (agenda item 11)

BF commented that the paper did not address how the Trust monitors the impact of cost improvements during the year. TB responded that during 2013/14 the Quality Impact Assessment was reviewed on a quarterly basis and this will be repeated during 2014/15; however, enhanced levels of review may be required throughout the year. BF added that the Trust may not have the scope in 2014/15 to advise against red/amber rated cost improvements and he asked that the Trust learns from the experience of achieving savings this year against the level needed in 2014/15.

In terms of process, Karen Holland (KH) confirmed that the challenge events for each BDU and support services does look in detail at the impact of each cost improvement and areas of risk are raised with the Directors of Nursing and Human Resources, and the Medical Director, then to EMT.

PA was still concerned about the ongoing cumulative effect of cost improvements and the increase in risk. He asked if the Committee needed a view from management of the risk areas and how these are managed as more challenging and riskier cost savings begin to come through. It was agreed to receive a further report at the next meeting with a more detailed analysis and review process through the Committee.

Action: Tim Breedon

CG/14/12 Themes from unannounced visits (agenda item 12)

KH made the following points.

- The key is to balance the themes across visits with awareness at ward/unit level of specific feedback.
- Each unit has its own feedback to develop an action plan.
- Within each BDU, governance groups receive BDU reports and are responsible for ownership and oversight of implementation.
- There will be follow up during the next round of visits to ensure actions are implemented.

For assurance, it was agreed to receive reports from each governance group at the next meeting, which will include actions arising from the unannounced visits. For the future visits programme, the Committee asked for a rolling report on serious concerns and issues raised during the year and an annual report on themes and outcomes. This will be included as a standing item on the Committee's agenda.

Action: Karen Holland

AGD confirmed that estates issues arising from the unannounced visits are reported into the Estates TAG.

CG/14/13 Trust approach to supporting service users into employment (agenda item 13)

TB introduced this item for DS and commented that, although this is a target for the Trust, the Trust is not in control of the mechanisms for achieving it. Whilst the Trust will do everything it can to support people back into work, not all 'work ready' initiatives can be included. JF commented that she would like to see the Trust be more proactive in the support given to people and an identified lead confirmed for this area of work. AGD commented that employment/labour market information would help inform an assessment of how well BDUs are performing and suggested development of a strategic approach is needed. It was agreed to flag this with Trust Board as an area of concern for the Committee given the high percentage of Trust service users who are out of work. The Committee felt that more could be done though a Trust-wide strategy with accountability at operational level to deliver more positive outcomes as part of the transformation programme.

Action: Helen Wollaston/Tim Breedon to take back to EMT

CG/14/14 Managing aggression and violence annual report (agenda item 14)

TB highlighted three areas.

- The British Institute of Learning Disabilities (BILD) accreditation.
- Incidents of physical violence, which have reduced year-on-year.
- As lead Director, TB has asked for the 2013/14 report to be produced earlier highlighting the impact of work done and benchmarking with other organisations.

CG/14/15 Information Governance Toolkit (agenda item 15)

At the end of January 2014, 74.4% of staff had undertaken information governance training. It is likely that the target will be achieved at the year-end. Information sharing will be a key issue in 2014, particularly in relation to safeguarding; however, this will present a number of risks. The Trust will adopt a proactive approach to ensure information governance does not become a barrier.

TB also commented that he is receiving increasing queries in the past few months in his role as Caldicott Guardian, which demonstrates an increased awareness.

CG/14/16 Undetermined deaths audit report (agenda item 16)

KH highlighted the key findings from the audit. NHB commented that, for the first time, deaths in three localities were above that expected. Proactive work has begun in Kirklees, which should be continued and disseminated to other BDUs. It focuses on three areas:

- a piece of work to train staff in risk awareness/assessment of suicide;
- transformation of crisis/home-based treatment teams; and
- a consistent policy for crisis/home-based treatment teams.

CG/14/17 Discussion items (agenda item 17)

Care Quality Commission update (agenda item 17.1)

NHB is preparing a paper with the Chief Executive on the experience from the CQC's new inspection regime for mental health trusts and learning for the Trust, which will be shared with the Committee.

Action: Nisreen Booya

CG/14/18 Issues to bring to the attention of Trust Board (agenda item 18)

The Committee agreed the key issues to raise during the meeting.

CG/14/19 Date of next meeting (agenda item 19)

The next meeting will be held on Tuesday 15 April 2014 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield. The Committee agreed that it would scrutinise the transformation proposals at its next meeting.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 25 February 2014

Present:	Julie Fox	Non-Executive Director (Chair)
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Non-Executive Director
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
In attendance:	Peter Aspinall	Non-Executive Director
	Mike Atter	Consultant Psychiatrist, Kirklees
	Julie Carr	Mental Health Act/Mental Capacity Act Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Yvonne French	Assistant Director, Legal Services
	Lorraine Jeffrey	Independent Associate Hospital Manager
	Geoff Naylor	Independent Associate Hospital Manager
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
Apologies:	**Members**	
	Dawn Stephenson	Director of Corporate Development
	Attendees	
	Kyra Ayre	Acting Head of Service, Mental Health and Assessment and Care Management (Barnsley) – local authority representative
	Paul Gillespie	Workforce Development (Wakefield) – local authority representative
	Antonis Lakidis	Associate Specialist, Calderdale

MHAC/14/01 Welcome, introduction and apologies (agenda item 1)

Julie Fox (JF) welcomed everyone to the meeting. The apologies, as above, were noted. The Committee also noted that Craig Limbert no longer occupies the AMHP Manager role in Kirklees. His replacement, Anne Howgate, takes up post on 3 March 2014 and will be invited to attend the Committee as the Kirklees Council representative.

MHAC/14/02 Compliance and Assurance Pathway Presentation (agenda item 2)

Mike Atter, Consultant Psychiatrist, Assertive Outreach Team, Kirklees, and Responsible Clinician at Enfield Down, presented on the discharge pathway and the different options available for discharge. The presentation was well received and all present found the care study approach particularly helpful.

MHAC/14/03 Legal update/horizon scanning (agenda item 3)

Care Quality Commission (CQC) approach to inspecting specialist mental health services

The Committee noted the new approach by the CQC for inspection of specialist mental health services, which will focus on the care people receive in the community, including the experience of people on Community Treatment Orders, how community mental health services work with other organisations to support recovery and ensuring that people's rights are protected. Engagement with people who use services will be central to the new approach and complaints will be a key source of information. Tim Breedon (TB) commented that the new approach will have implications for the Trust and he provided assurance in response to the concern expressed by Peter Aspinall (PA) that Business Delivery Units (BDUs) are aware of the requirements and there are a number of metrics to demonstrate to Trust Board that services meet the expectations of the CQC.

CQC monitoring of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)
A key finding of the CQC, which is supported by evidence to the House of Lords, is that the Mental Capacity Act is not understood and implemented consistently across health and social care services. The CQC will focus on ensuring policies and procedures comply with the Act, and that there is informed and effective use of DoLS.

CQC monitoring of the Mental Health Act
Yvonne French (YF) took the Committee through the key findings in the CQC's fourth annual report. There will be an internal review of Trust practice against the findings and an action plan developed. JF asked that this is presented to the next meeting in May 2014.

Action: Tim Breedon/Yvonne French

Section 117 aftercare/accommodation briefing and Transfer of detained patients and duty of fairness
Both briefings were noted.

MHAC/14/04 Minutes from the previous meeting held on 6 November 2013 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 6 November 2013.

MHAC/14/05 Matters arising from previous meeting (agenda item 5)

There were eight matters arising.

MHAC/13/13 Yorkshire Ambulance Service
TB reported that the meeting with the Service has yet to be arranged. It was agreed to receive a further update at the next meeting.

Action: Tim Breedon

MHAC/13/28 Consistent application of definition of urgent and crisis admissions
Nisreen Booya (NHB) explained that there are currently two standards for assessment:

- four-hour crisis (which creates significant pressure on the system as referrals are escalated);
- fourteen days routine.

The transformation programme will propose introduction of a third level:

- three to five days (urgent).

This would relieve pressure on crisis services and would also serve to eliminate inconsistent application of assessments by community mental health teams (CMHTs) where individuals are known to services and are then transferred to crisis teams rather than a CMHT handling the referral itself.

MHAC/13/29 Place of safety suites (Section 136)
TB commented that the Concordat (see item MHAC/13/34) may raise a number of issues increasing the need for Section 136 suite beds. Whilst the level of provision currently is sufficient, this may not remain the case and a review of the current provision may be needed with commissioners. TB will quantify what the Concordat could mean in terms of demand and report back to the next meeting.

Action: Tim Breedon

The data will also be checked for admission into Section 136 suites of any individuals under the age of eighteen.

Action: Tim Breedon

MHAC/13/34 Department of Health (DoH) guidance
The DoH has issued a document, Mental Health Crisis Care Concordat, as part of the post-legislative scrutiny of the Mental Health Act. The Trust will assess the implications for the Trust and bring an update back to the Committee.

Action: Tim Breedon/Yvonne French

In relation to the document discussed at the last meeting from the DoH, YF confirmed that the Trust has addressed the areas it can and will wait for further guidance to address other areas.

MHAC/13/34 DoLS action plan
Two areas were identified for the Trust to address:

- an inter-agency protocol for transporting service users (see item MHAC/13/13);
- a use of taser policy, which is now in place.

MHAC/13/37 Advocacy services
YF has agreed quarterly meetings to share information and data.

MHAC/13/37 Mental Health Act/Mental Capacity Act training
An e-learning programme has been developed, and was welcomed by the Committee, to ensure a consistent approach across the Trust. The Committee did question whether staff would be more inclined to take-up e-learning as opposed to a more traditional form of training. The Committee also suggested that the Trust should protect the content and format of the training in some way to share with other Trusts.

MHAC/13/38 Recording of information
A process has been agreed to record Section 132/Section 17/absence without leave data on RiO with accompanying process notes for BDUs.

MHAC/14/06 Committee annual report (agenda item 6)

The Committee considered the draft annual report to Trust Board and agreed it should include the findings of the internal audit report on corporate governance (see item MHAC/14/07).

Action: Bernie Cherriman-Sykes

There were no changes to the Terms of Reference and the work programme was approved. The annual report will be presented to the Audit Committee on 8 April 2014.

Jonathan Jones left the meeting at this point.

MHAC/14/07 Audit and Compliance Reports (agenda item 7)

Community Treatment Orders (CTO) audit
JF asked if the Trust should be concerned with the increase in CTOs, whether consistent with national trends or not. NHB responded that it reflects the increase in treatment of individuals in the community. The complex management and administration of CTOs could explain the inconsistent approach across BDUs. Some patients may find CTOs more restrictive than admission to in-patient services. Geoff Naylor (GN) commented that Hospital Managers were concerned about the criteria for repeat renewals.

There were three recommendations from the audit in relation to ongoing monitoring and benchmarking, circulation of the outcome of the audit to appropriate teams to raise understanding of the requirement to give patients their rights and inclusion of Section 132A recording facility on RiO, and these will be actioned.

Section 17 leave and cancellation of leave
The Committee noted that there were only a small number of instances where leave was cancelled due to low staff numbers. It was agreed to look further at the eleven instances to ensure all other alternatives had been exhausted before leave was cancelled.

Action: Yvonne French

Two recommendations were made in relation to a single recording format with guidance and a re-audit in six months. JF asked that the outcome of the repeat audit is reported to the Committee in August 2014.

Action: Yvonne French

Corporate governance audit
The report was noted.

Mental Health Tribunal audit
The report was noted. It was suggested repeating the audit next year, including ethnicity.

Action: Yvonne French

MHAC/14/08 Care Quality Commission Visits (agenda item 8)

TB explained that this agenda item was split into two parts relating to:

- recent visits; and
- outstanding actions/progress reports for estates (through Estates TAG monitoring) and clinical (through updates from BDUs).

Recent visits/Outstanding actions/progress report
The four monitoring visits to Clarke ward (Barnsley, 19 September 2013), seclusion unit visit to Newton Lodge (24 October 2013), Enfield Down (Huddersfield, 23 November 2013), and Ashdale (Calderdale, 26 November 2013) were noted. The Committee particularly noted the positive comments made by the CQC in the reports on Ashdale and Clarke wards.

TB confirmed that BDUs are responsible for providing assurance on action, which YF collates for clinical actions and Alan Davis for estates. PA expressed a degree of concern in relation to the plethora of recommendations arising out of CQC Mental Health Act visits and how the Committee can be assured that these are being addressed at an operational level.

The Committee was also pleased to note that work to upgrade seclusion units was progressing to time.

The Committee agreed that, once an action is reported to the Committee as 'complete', it can be removed from the report.

MHAC/14/09 Monitoring Information (agenda item 9)

Paper 3 – Transfers
The report was welcomed, providing an understanding of movements and the reasons for them. Although there are no apparent themes, in some cases, the Committee would need the detail of an individual transfer to understand the reasons behind it. The report will also

identify any major issues around bed pressures, use of Section 136 suites and the need for specialist care not provided by the Trust.

No further issues were raised on the monitoring information.

Local authority information

Calderdale – Ian Priddey (IP) reported on the current position with Approved Mental Health Practitioners (AMHP) in Calderdale. The Committee asked that the position is raised by the Trust with Calderdale Council, through the Integrated Governance Board, due to the potential difficulties in covering rotas.

Action: Tim Breedon

YF updated the Committee on behalf of Paul Gillespie in relation to Wakefield, which has ten trainee AMHPs during 2014/15 providing a healthy position for Wakefield. YF was asked to obtain an update from Barnsley and Kirklees.

Action: Yvonne French

IP also commented that concerns remain in Calderdale and Kirklees regarding difficulties with the Police in assisting community mental health assessments and conveying individuals, which is a national issue.

Hospital Managers' Forum

The Forum notes from 21 November 2013 were received and noted. GN drew the Committee's attention to items 2a) and 2b) in relation to mileage. This will be raised with YF separately.

The Committee also noted that David Longstaff has been nominated to attend the Committee if GN or Lorraine Jeffrey (LJ) are unable to attend.

In relation to the concerns raised by the Trust about confidentiality of notes, GN promised to raise again at the next Forum meeting.

LJ reported that there appears to be an increase in patients being given reports at or just before a hearing. YF agreed to follow up internally.

Action: Yvonne French

MHAC/14/10 Matters Arising (agenda item 10)

Recruitment of Hospital Managers

The report was noted. There is a good spread across districts and there was not thought to be any need to recruit additional managers; however, there may be a need to review arrangements to chair hearings given the geography covered. JF also commented that she would like to see a good balance of age, gender and ethnicity if the Trust was to recruit additional Hospital Managers.

Staff authorised to accept Section papers

The Committee noted that an additional eleven staff have been trained to accept section papers.

MHAC/14/11 Key messages for Trust Board (agenda item 11)

The key issue to report to Trust Board is the CQC inspection regime, particularly the focus on community services.

MHAC/14/12 Date of next meeting

The next meeting will be held on Tuesday 13 May 2014 from 14:00 to 16:30 in the Wainhouse room, 5th floor, F Mill, Dean Clough, Halifax.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Remuneration and Terms of Service Committee held on 4 February 2014

Present:	Ian Black	Chair of the Trust (Chair)
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust
	Steven Michael	Chief Executive
Apologies:	None	
In attendance:	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/14/01 Welcome, introduction and apologies (agenda item 1)

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

RTSC/14/02 Minutes of the previous meeting held on 15 October 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes from the meeting held on 15 October 2013.

RTSC/14/03 Matters arising from previous meeting (agenda item 3)

RTSC/13/53 Director of Service Improvement and Health Intelligence

Steven Michael (SM) updated the Committee on the position in relation to this post. Diane Smith has been appointed as Interim Director of Service Innovation and Health Intelligence on secondment from NHS England working three days per week for a six month period. He reminded the Committee that she was considered to be 'above the line' at interview but a decision was made not to appoint to the post at the time. SM has set a number of objectives for the secondment, including development of a position statement of 'raw' intelligence to support the transformation programme within her first month.

Jonathan Jones (JJ) asked whether this would be a part-time role in the future. SM responded that he was unsure at the current time. Helen Wollaston (HW) observed that initial feedback is that three days could easily be spent on corporate activity, such as meetings, and, therefore, this needs careful review before any decision on time commitment is made. IB advised that Diane Smith will attend the business and risk meetings of Trust Board, as with Business Delivery Unit (BDU) Directors, during the time of her secondment.

JJ was keen that the arrangement should not go beyond a certain date and that the Trust should know by then its preferred option. SM agreed that the end of the secondment (that is, six months) is the cut-off point and he will bring an update on the position to the next two meetings.

Action: Steven Michael

RTSC/13/56 Medical staff performance

HW, as Chair of the Clinical Governance and Clinical Safety Committee, will commission a paper, through the Committee, on the governance of the processes and systems in place to manage the performance of medical staff, particularly consultants, and how this operates within the Trust.

Action: Helen Wollaston

RTSC/14/04 Human resources exception report (agenda item 4)

Sickness absence

IB commented that the Trust struggles to achieve the sickness target and, as this is a matter that concerns Trust Board, it takes up some considerable time at each Trust Board meeting. His preference would be to discuss the Trust's performance on sickness absence and other HR performance-related issues in detail prior to the quarterly business and risk Trust Board meeting. It was agreed to review Committee dates for 2014 to facilitate this.

Action: Alan Davis

SM commented that Bernard Fee made a good point at Trust Board about receiving an operational delivery perspective from BDU Directors on workforce performance as they are responsible for implementing Trust policies and procedures. Alan Davis (AGD) commented that sickness absence is often an indicator of other issues within teams/services and that robust monitoring of performance should continue; however, it would be very difficult to achieve further savings.

In terms of the target for 2014/15, AGD commented that the Committee must remember that the Trust is already performing well in comparison with other Trusts in Yorkshire and the Humber. JJ commented that he would like to see a sensible, achievable target in place that drives good performance and can be used as a management tool that the Executive Management Team (EMT) can use. IB added that he would wish to the target to remain at 4% given that seventeen service lines are currently meeting the target, which demonstrates it is achievable. SM asked for an analysis of the service lines that meet the target and those that do not, mitigating action, a more detailed review of outliers, both in terms of teams and individuals, and identification of underlying issues.

Action: Alan Davis

JJ asked to what extent absence performance was used in Directors' objectives. SM responded that sickness was not an explicit objective in 2013/14 but he would support inclusion in 2014/15 but as an individual objective, where appropriate, rather than a gateway target. He added that he would not want this to result in holding AGD as Director of Human Resources to account for what is an operational issue.

AGD commented that the frameworks in place are robust and strong and the ambition, therefore, should be to achieve the 4% target. This also links to the Trust's values and the expectations of individuals on appointment. He added that services are now far more proactive in managing absence and in seeking specialist human resources' support.

The Committee acknowledged that, whilst it is aware that the Trust is underperforming in some areas against this target, it had been seen as a stretching target, performance is good in comparison to the Trust's NHS competitors and, in most areas, there is a good performance trajectory.

NHS staff survey – Trust results

AGD outlined the highlights from the survey results, particularly the proportion of staff who would recommend Trust services to family or friends and the numbers of staff who have had an appraisal. Health and safety, and equality and diversity training were two disappointing areas. On the whole, the results are a balanced set of outcomes, which will be mapped against the outcomes from the wellbeing survey. Robertson Cooper will run a series of workshops with staff in relation to individual team/service results. A significant piece of work around bullying and harassment is currently being discussed with staff side.

SM commented that there are some areas where the Trust has improved and some areas where the Trust would have wanted to improve; however, the Committee does have to bear in mind the sample size, particularly in relation to the wellbeing survey. AGD added that his

main worry is that the analysis is formed of comparison of averages and the Trust, therefore, needs to understand its position in relation to other Trusts.

IB commented that not much qualitative analysis comes from this survey and he asked for views on what would be seen as important. For SM, this would be:

- recommendation to family and friends;
- care of patients/service users being the Trust's top priority;
- recommendation of the Trust as a place to work;
- staff do their job to a good standard; and
- staff are satisfied with the quality of the care they can give.

The Committee noted that the results will be reported to the Members' Council and staff side, and an analysis of the results will be included on the Trust's website and in its annual report.

RTSC/14/05 External review of Directors' remuneration: terms of reference (agenda item 5)

SM updated the Committee on the external review of Directors' remuneration. This will form three parts:

- a review of Executive Directors' (that is, voting) payscales;
- a broader review of the arrangements for all Director posts; and
- a review of retention packages.

Capita will be asked to undertake the review alongside the review of Chair and Non-Executive Directors' remuneration (although it was noted that the two reviews are not connected and have different approval processes).

It was the view of the Committee that the review should primarily use benchmarking within the NHS but should include some external comparison against the wider health and social care sector.

HW asked for clarification of 'defensible' in the second aspect of the review and commented that defensible to whom needs to be clear in the context of the current climate.

IB asked what timescales Capita would be working to and AGD responded that he intended to bring a report back to the April meeting.

Action: Alan Davis

AGD confirmed that the performance related pay element of Directors' packages would be included in the report. JJ's comment that he would like to see accountability of Directors reflected in the proposals was noted.

RTSC/14/06 Directors' performance related pay update (agenda item 6)

SM reminded the Committee of the two elements of the Scheme. The gateway is made up of three parts:

- financial performance;
- compliance with regulators/quality;
- service transformation.

Achievement will have a multiplier effect for performance against individual objectives.

Both financial performance and compliance are in a healthy position and this is likely to continue; therefore, both are likely to be achieved throughout the year. However, the position on service transformation is not as healthy. SM has reviewed the position through EMT and has asked for more regular meetings with individual Directors responsible for transformation. He gave the Committee an update on each transformation workstream. The Committee agreed that an assessment of 6/10 would be the minimum to pass the gateway.

RTSC/14/07 Clinical Excellence Awards (agenda item 7)

AGD explained that there was one individual who ranked first but, as that individual had received an award last year and there was nothing exceptional in the application this year, the panel had decided not to make an award.

AGD tabled the gender and ethnicity comparisons. The Committee also asked to see the spread by service line and locality, and the correlation between involvement in leading transformation/service improvement with an award.

IB commented that this was a clinically-led process and the panel was far more robust in its assessment of the applications. Thirteen awards were made against a maximum possible for the Trust of fifteen.

It was RESOLVED to RATIFY the awards outlined in the paper, payable from 1 April 2013.

RTSC/14/08 Mutually agreed resignation scheme (MARS) – update (agenda item 8)

The Committee confirmed its RESOLUTION to APPROVE the application under MARS (given by email on 30 January 2014).

RTSC/14/09 Update on leadership and management structures (agenda item 9)

SM updated the Committee and confirmed that the structure had been rationalised to good effect with a good balance between voting and non-voting Directors and a leaner structure. The focus is now on establishing second tier support. It is the intention for BDU Directors to be outward-facing to build good relationships with partners at a strategic level supported by sound operational deputies. The key focus for deputies will be operational management of the next level, which will see a triumvirate arrangement established of clinical/medical lead, Practice Governance Coach and general management. The key challenge is to identify clinical/medical leads. This is a great opportunity to appoint individuals with a different approach.

There is also an intention to bring together clinicians with entrepreneurial thinking into an informal transformation network to support the system.

The issue for the Trust is to develop home-grown leadership and management talent through effective leadership and development processes given the lack of suitable candidates externally. The key will be to recognise where talent is emerging across the organisation. AGD is currently advertising for a Head of Leadership and Management Development to support the development of a leadership and management framework.

In terms of the Talent Pool, 125 staff have joined and individuals are beginning to get involved in projects and initiatives within the Trust. The next step is to identify key roles

where the Trust needs to grow individuals to fill posts internally and identify who these individuals are.

SM has commissioned a review of the Quality Academy to assess support services and back office ability to support the transformation and what support will be needed in the future. A specification will be completed by the end of January 2014 and procurement process will begin. HW suggested inclusion of capacity to evidence the outcome of transformation as one area of expertise required.

RTSC/14/10 Committee annual report and work programme (agenda item 10)

IB explained the background and what the Committee was being asked to approve. It was agreed to include approval of MARS applications and to include ratification of Clinical Excellence Awards at this meeting. It was agreed there were no changes to the Committee terms of reference. The outcome of the self-assessment will be included in the report.

In terms of the work programme for 2014, it was agreed that the Committee would take a detailed look at the effect of the transformation programme on workforce, and leadership and management in June and September 2014.

It was RESOLVED to APPROVE the annual report for 2013/14 for presentation to the Audit Committee in April 2014.

RTSC/14/11 Any other business (agenda item 11)

Non-Executive Directors' appraisal arrangements

IB confirmed he would use the same process as last year in terms of a review of what has been achieved, achievements in the coming year and personal development. He would welcome Executive Directors' views, particularly where a Director is lead Director for a Committee. SM agreed to re-circulate the proforma used last year, which will include an assessment of the contribution to Trust Board and its Committees.

Action: Steven Michael

Medical leadership remuneration

It was agreed it would be timely to review the sessional payments arrangement, which has been ad-hoc to now, to ensure there is a consistent approach across the Trust. This will form an agenda item in April 2014 and will also link to the review of the Medical Director's remuneration.

Action: Alan Davis

RTSC/14/12 Date of next meeting (agenda item 12)

The next meeting will be held on Tuesday 1 April 2014 at 14:00 in the Chair's office, block 7, Fieldhead, Wakefield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 6

Title:	**Strategic delivery framework and corporate objectives 2014/15**
Paper prepared by:	Chief Executive
Purpose:	The purpose of this paper is to enable Trust Board to confirm the strategic delivery framework for 2014/15.
Vision/goals:	The strategic delivery framework sets the context and priorities for strategic corporate objectives for 2014/15.
Any background papers/ previously considered by:	Considered by Trust Board at its strategic session in February 2014.
Executive summary:	The attached strategic delivery framework and associated performance metrics provide a framework for the Trust's strategic corporate objectives for 2014/15 and are based on the discussion at the strategic session in February 2014. The framework will support the development of the Trust's annual and five year plans. The framework shows a clear line of sight from the Trust's mission and values co-produced with service users, carers, staff and other key stakeholders during 2014/15 through to the Trust's goals, based around stakeholder priorities identified through the recent transformation events. The goals of the organisation will be supported by the alignment of transformation, planning and delivery through corporate objectives set against seven distinct delivery areas. These will operate at a number of levels (Trust-wide, Business Delivery Unit, service line and team). The delivery objectives will be underpinned by organisational development objectives (the 'how') utilising the 4+2 'What Really Works' framework. This approach will be supported by a clear structure at all levels focusing on BDU and Quality Academy progression. The first cut is at a Trust-wide Quality Academy level, which, if supported by Trust Board, will be cross-referenced to BDU delivery objectives and will inform a more granular set of key performance indicators including responsibilities and timeframes.
Recommendation:	**Trust Board is asked to approve the strategic framework and underpinning delivery and organisational development objectives.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

STRATEGIC FRAMEWORK AND CORPORATE OBJECTIVES 2014/15
DRAFT V5

Mission

Our mission
Enabling people to reach their potential and live well in their community

Values

Our values
- **Honest, open and transparent**
- **Respectful**
- **Person first and in the centre**
- **Improve and be outstanding**
- **Relevant today, ready for tomorrow**
- **Families and carers matter**

Goals

Our goals
Do the day job well, delivering quality and financial targets

Delivery the transformation

Manage our partnerships

Stakeholders

Stakeholder priorities
1. I want services which keep me in the centre and which focus on my potential
2. If I choose to make use of technology I want it to be available
3. I want all organisations, both big and small, to work together so I don't see the joins
4. I want people to recognise early on that I'm beginning to have problems and to help me
5. I want you to offer me as much choice as possible and help me understand those choices
6. I want you to support my family and carers

Strategic objective

Our strategic objectives
1. Define the organisational form required to deliver sustainable services, including exploration of new strategic partnerships to create and utilise alternative capacity.
2. Develop integrated models of care with acute, community, third sector and local authority partners.
3. Broaden clinical networks, specifically for forensic services.

Priorities

Our service priorities
1. Integration of urgent care pathway (whole system efficiency)
2. Significant improvement in outcomes in LTCs (mental physical, social) – parity of esteem
3. Health and Well Being – self care and prevention
4. Recovery, self care and improved use of technology (people in control)
5. Healthy communities / alternative capacity / social capital
6. Specialist Services – critical mass

Delivery

Our delivery objectives

Quality

1. Create a person-centred delivery system.
2. Deliver safe services.
3. Ensure efficient and effective delivery.

Finance

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

Workforce

1. Development of workforce plan linked to service and financial objectives.
2. Development of values-based Human Resource Management to enhance service quality.
3. Improve organisational performance through strong workforce engagement.

Estate

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

IM&T

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

Commissioners

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

Partnerships

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

Organisational Development

Our OD support objectives

Strategy

1. Embed the mission across the Trust to enable people to reach their potential and live well in their community.
2. Embed the values across the Trust to focus not just on what we do, but how we do it.
3. Encourage and foster a recovery approach to delivery of services across the Trust.

Execution

1. Embed recording and utilisation of patient experience data (knowing what the customer wants).
2. Delegate decision-making to the frontline to improve quality and use of resources.
3. Translation of patient and commissioner requirements into service improvement.

Culture

1. Values-based induction with probationary period for new starters.
2. Improving the patient experience through values-based appraisal.
3. Six-monthly staff wellbeing and engagement survey.

Structure

1. Review of Quality Academy fitness for purpose.
2. Reduce management layers to support decision-making closer to frontline.
3. Develop and implement partnership and shared leadership and management arrangements for general management, clinical leadership and practice governance.

Partnerships

1. Utilise the partnering 7-step model to assess the nature and intent of the partnerships the Trust enters into.
2. Continue to build on the strong platform of partnership with staff through formal mechanisms and informal staff engagement.
3. Support staff to improve their partnering skills with service users and carers through a values-based approach to service delivery.

Leadership

1. Leadership competency framework to clearly state competencies and behaviours required.
2. Development of values-based Leadership Development Programme, providing tools and techniques to support development of the right skills.
3. Development of local pay arrangements which reward and incentivise values-based delivery systems and supports high quality care.

Innovation

1. Introduce ImROC principles within the organisation.
2. Strengthen and embed Creative Minds Strategy.
3. Embed use of R&D in service improvement.

Talent

1. Development of talent management programme and succession planning for key organisational roles.
2. E-appraisal linked to talent management.
3. Develop staff suggestion programme.

Key performance indicators

Delivery objectives

Quality	Finance	Workforce	Estate	IM&T	Commissioners	Partnerships
1. Achieve top 20% for patient experience surveys. 2. Achieve 95% compliance on care planning. 3. Achieve 95% in all CQUINS related to service access.	1. Meet normalised EBITDA and surplus targets at Trust and BDU level. 2. Financial risk rating >3. 3. Evidence based on return on investment for existing and new services.	1. Generic job descriptions to support the transformation of health care support workforce. 2. Three-yearly programme of 360 degree appraisal implemented. 3. Six-monthly survey results built into HR performance dashboard.	1. Development of Calderdale community hub business case and commence capital scheme. 2. Development of disposal programme and Trust Board agreement to key hospital site development. 3. Agree Fieldhead master plan and commence decant scheme.	1. Improved productivity and service offer by more effective deployment of staff (key metrics). 2. Improved quality, safety and productivity through information sharing (key metrics). 3. Performance platform and scorecard, which supports drill down to team level and trend analysis.	1. Retention of core contracts and evidence of productivity gains for commissioners. 2. Clear service offer, including benefits from Trust on integrated community services. 3. Plan for targeted growth or disinvestment in services to improve contribution and financial/service sustainability.	1. Member of local Partnership Boards. 2. Co-production of Strategic Outline Case (outline and full business case) and signing of memorandums of understanding and/or service level agreements with third sector partners. 3. Increase in income from new businesses by 0.5%.

OD support objectives

Strategy	Execution	Culture	Structure	Partnerships	Leadership	Innovation	Talent
1. Positive friends and family outcome. 2. Delivery of the Year of Values. 3. Establish recovery colleges linked to development of alternative capacity, such as Creative Minds.	1. Evidence of outcomes and experience reporting influencing marketing and improvement of services. 2. Review of Scheme of Delegation and evidence of improved performance (metrics scorecard). 3. Incorporation of rate of return evaluation in key service changes.	1. Stability rate for new starters linked to probationary period. 2. Managers' wellbeing survey results linked to 360 degree appraisal. 3. Wellbeing survey to increase by 10% year-on-year.	1. Implementation of agreed action following Quality Academy fitness for purpose review. 2. Reduction in management, administration and overhead costs. 3. General Managers, Clinical Lead and Practice Governance Coaches appointed.	1. Monthly review of rich picture and 7-step model at EMT. 2. Attendance at Trust Partnership Forum. 3. Delivery of year of values programme.	1. Production of leadership strategy and framework, which defines what behaviours and competencies are required and an implementation plan. 2. Coherent and consistent programme of leadership development with evaluation criteria to demonstrate impact. 3. Implementation of local pay arrangements which reward values-based service delivery and high quality care.	1. Recovery Colleges established and evidence of effectiveness. 2. Creative Minds partnerships increased by 10%. 3. Evidence of application of R&D supporting improved outcomes	1. Evidence of growth in talent through recruitment and retention and development of individuals for future posts Identify key roles and talent pool. 2. Appraisal feeds into talent pipeline and stretch opportunities. 3. Development and progression of staff from the talent pool.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview

Month 11 2013/14

Table of Contents

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 11 2013/2014 (February 2014 information unless stated). The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

HIGH LEVEL PERFORMANCE SUMMARY (YEAR TO DATE)

OUTCOMES	RAG RATING
• Monitor Governance Risk Rating	G
• Monitor Finance Risk Rating	G
• CQUINs	A/G

CUSTOMER FOCUS	
• Complaints	G
• Members council	G
• Annual community survey	A/G

OPERATIONAL EFFECTIVENESS	
• Case load management (7 day follow-up; CPA review; gate kept; DTOC)	A/G
• Data Quality	G

FIT FOR THE FUTURE WORKFORCE	
• Sickness	A/G
• Training	A/G
• Appraisal	G

Trust Board Performance Dashboard – Vital Signs (Month 11 2013/14)

Business Strategic Performance: Impact & Delivery

Month 11 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)	4.1	4.1	✓	–	4
CQC	CQC Quality Regulations (compliance breach)	Green	2	▲	–	3
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	Green	✓	–	3
IAPT	IAPT Kirklees: % Who Moved to Recovery	52%	55%	✓	↑	4
Inf' Prevent'	Infection Prevention (MRSA & C.Diff) All Cases	0	0	▲	↑	3
C-Diff	C Diff avoidable cases	0	0	✓	↑	4
PSA Outcomes	% SU on CPA in Employment	10%	**7.7%**	✗	↓	4
	% SU on CPA in Settled Accommodation	60%	**69.6%**	✓	↓	4

Customer Focus

Month 11 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	4% 2/57	✓	↑	4
MAV	Physical Violence - Against Patient by Patient	19-25	Within ER	✓	–	4
	Physical Violence - Against Staff by Patient	51 - 65	Above 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%	81%	✓	–	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	> 50%	85%	✓	↑	4
	% of Quorate Council Meetings	100%	100%	✓	–	4
Membership	% of Population Served Recruited as Members of the Trust	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%	50%	▲	↑	3
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	> 80%	100%	✓	↑	4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	> 90%	100%	✓	–	4

Operational Effectiveness; Process Effectiveness

Month 11 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**2.5%**	✓	↓	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**99.2%**	✓	↓	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	97.6%	✓	↑	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**94.9%**	▲	↓	4
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	29.46%	▼	↓	1
Data Quality	Data completeness: community services (Monitor)	50%	94%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.3%**	✓	–	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**82.4%**	✓	↑	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	95.0%	✗	↑	4
	% of eligible cases assigned a cluster within previous 12 months	100%	78.5%	✗	↑	4
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**99.4%**	✓	↑	4

Fit for the Future; Workforce

Month 11 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Appraisal	% of Staff Who Have Had an Appraisal in the Last 12 Months	>=90%	92.3	✓	–	4
Sickness	Sickness Absence Rate (YTD)	<=4%	4.8	▼	–	3
Vacancy	Vacancy Rate	10%	5.1%	✓	–	4
Safeguarding	Adult Safeguarding Training	80%	82.1%	✓	–	4
Fire	Fire Attendance	>=80%	79.9	▲	–	4
IG	IG Training	>=75%	91.5	▲	↑	4

Overall Financial Position

	Performance Indicator	Month 11 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assurance
	Trust Targets				**10**	**9**	**8**	**7**	**6**	**5**	
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	●	●	●	4
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	●	●	●	4
3	Capital expenditure within 15% 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 year to date position, as at February 2014, is showing a net surplus of £3.7m which is £0.1m marginally ahead of plan. The forecast for the year remains consistent at £3.8m which is £0.04m marginally ahead of plan.
2. At February 2014 the cash position is £32.8m and is £4.4m ahead of plan.
3. Capital expenditure to February 2014 is £6.4m which is £0.6m behind revised plan. The forecast remains that the capital programme will be delivered in full.
4. At Month 11 the Cost Improvement Programme is £0.2m (approx 2%) under the target of £7.96m.
5. The Monitor Financial Risk Rating scores 4 against a plan of 4. (Under the Risk Assessment Framework a score of 4 is the highest rating.)
1. At 28th February 2014 92% of NHS and 95% of non NHS invoices have achieved the 30 day payment target. (95%)

Financial Risk Rating 2013/14

	February 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	9.8 times	4	5.8 times	4
Liquidity	18.8	4	12.8	4
Weighted Average		4		4

Under the Monitor Risk Assessment Framework change implemented in October 2013 the Trust financial risk rating is revised from 5 ratings to the 2 above. These are designed to demonstrate that a Trust remains a 'Going Concern.' These are scored on a 1 – 4 rating, with 4 being the highest.

Financial Risk Rating 2013/14

	February 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.7%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.7%	5	5.7%	5
I&E surplus margin	2.8%	4	2.4%	4
Liquid ratio	33	4	27.9	4
Weighted Average		4.1		4.1

The table above shows the previous regime for Trust financial risk rating. These metrics will continue to be monitored in shadow form for the remainder of 2013 / 2014. These are rated on a 1 – 5 measure.
Overall the Trust continues to perform better than planned against all of these metrics.

Flawless Execution

PERFORMANCE OVERVIEW

1.0 IMPACT AND DELIVERY

1.1 Monitor Compliance Framework

- The Trust measures for governance self-assessment against the new Risk Assessment Framework were implemented from October 2013. As at month 11 the Trust's self-assessed risk rating is green.

1.2 Care Quality Commission (CQC)

- There remain 2 compliance actions related to CQC visit to Fieldhead (Forensic and Trinity 2) - detailed action plan submitted in regard to the identified compliance issues to be fully completed by 31st May 2014.
- Still waiting for CQC report re: unannounced visit to Fox View (Kirklees).

1.3 CQUINs

1.3.1 Barnsley

Overall Performance Rating : Amber/Green

Key Risk Areas:

- Clinical Communication discharge communication datasets – Some risk remains in achieving target by quarter end.
- Increasing the number of people in secondary mental health in employment target not met, currently at 6.4% against a target of 7.81%. (6.1%% month 10) The target set is within realistic comparator group but will be difficult to achieve in the economic climate.
- Health and wellbeing BMI CQUIN:- services have undertaken some validation work on quarter 3 submission to ensure the CQUIN will be achieved by end Q4

1.3.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green

Key Risk Areas:

- 2.1a MH Access Crisis 4 Hours
  Kirklees are underperforming by 1.7% in WAA. Aggregated position 88.3% against target of 90%
  Wakefield are underperforming within WAA and OPS (89.6% and 75.0% respectively). Aggregated position 88.5% against target of 90%
- 2.2 (a&b) MH Access Routine 14 Days
  All 3 BDUs are currently failing achievement against the WAA target of 80%.
  Calderdale are underperforming by 60.2% pulling the aggregated position down to 72.8% against target of 80%.

Flawless Execution Continued

Kirklees are underperforming in both WAA and OPS (50.5% & 73.5% respectively). Aggregated position is 60.7%
Wakefield are underperforming by 3.3% in WAA, and achieving their aggregated position (82.9%)
All BDU CQUIN Leads are currently reviewing the cases under target.

- 2.3 (a) Access PTS Assessment 14 Days
  Calderdale, OPS are underperforming (50%). Small numbers are distorting the percentage (only 1 out 2 Service Users did not have an assessment completed within 14 days). Achieving aggregated position of 95.9%.
  Wakefield are underperforming within OPS (90.0%). Achieving aggregated position of 98.8%

Areas to Note:

- 2.1 (c&d) CAMHS Access Crisis (2hrs)(Wakefield Only)
  RiO reporting continues to show an underperformance in this CQUIN. However, the service are confident that this CQUIN is being achieved. Internal work continues between P&I and the Service to validate data.

- 2.2 (c&d) & Routine (4 Weeks) (Wakefield Only)
  RiO reporting is showing an underperformance in this CQUINs. Work is being undertaken internally with the Service to validate RiO figures with those that are manually extracted by the Service.

- 2.2 (a&b) MH Access Routine 6 Weeks
  This part of the Routine Access CQUIN is now starting to underperform in both Calderdale and Kirklees.
  WAA in Calderdale are underperforming at 93.9%. Achieving an aggregated position of 96.2%against a target of 95%
  Kirklees are underperforming in both WAA & OPS (92.6% & 90.1% respectively). Aggregated position 91.5%
  Wakefield are maintaining achievement within both WAA and OPS.
  ..

1.3.3 Forensic- Green

Forensic CQUINs are submitted on a quarterly basis.
Q3 Forensic submissions was made 29th January 2014. Feedback regarding achievement is still awaited from commissioner although, it is envisaged that all CQUINs will be achieved for Q3.

1.4 Infection Prevention

Hospital Acquired Infections -C Difficile: The month 11 position remains at 7 infections against the yearly target of 8 or under. The latest case was isolated in January 14, meaning that there were no cases in October, November or December. All cases (except January 14 which hasn't yet been to the ratifying panel) were deemed to be unavoidable. The possibility of breaching the target remains unchanged.

Flawless Execution Continued

1.5 PSA Outcomes

Month 11 data shows a continued under performance against the national Department of Health outcome measures % on CPA in employment (Target >10%).

Position in Barnsley has improved, Kirklees has remained the same and Calderdale and Wakefield have seen a decline compared to Month 10.

- Wakefield 6.8%, Kirklees 9%, Calderdale 7.8%, Barnsley 6.4% (Barnsley have a local target of 7.81%)

2.0 CUSTOMER FOCUS

2.1 Membership/befriending services

% of members actively engaged – efforts to engage members continue with an increase in active engagement since the previous quarter. The Trust's vision for volunteering may also have a positive impact on member involvement in future months

Befriending service – the befriender recruitment drive has had a positive impact on the number of service users allocated a befriender within 16 weeks and efforts in this area are continuing

3.0 OPERATIONAL EFFECTIVENESS

3.1 Breastfeeding

Over the last month the Health visiting service has been carrying out essential audits that are a requirement of the BFI programme. The audits will provide the service with an action plan to support an improvement in breastfeeding rates.

Since the meeting on the 29th January, 25 Champions have been trained and we are now working on how they can best support children's centres and other settings with the health agenda. Some of the Champions have had additional training on Health Start and smoking. We are holding a re-launch event of 23rd April and will continue to meet with key stakeholders over the coming months.

3.2 Mental Health Currency Development

External

- There will be no CQUINS for MH PbR in 2014/15. We will need to collect the relevant information against the specified measures in the guidance (except R7 - ICD10 Diagnosis).
- Capita have completed an Audit as part of a National Programme around MH currencies. Initial feedback seemed positive. The final report is expected in approximately 8 weeks.

Flawless Execution Continued

Internal

- Further analysis separating Medics and Non Medics is being looked at to hi-light any significant areas for improvement.

3.2.1 Mental Health Clustering

- The Mental Health Clustering team are focussing on improving the % of eligible clients reviewed within frequency in Q4, this targeted approach is on-going. An improvement has been achieved by Wakefield & Kirklees BDU's but declined in Calderdale & Barnsley.
- The % of service users with a care coordinator recorded has improved slightly across all BDUs with an additional 0.3% increase in February.

	Trajectories			Actual		
	% of eligible clients clustered	**% reviewed within frequency**	**% Care Coordinator recorded**	**% of eligible clients clustered**	**% reviewed within frequency**	**% Care Coordinator recorded**
Target	100%	100%	100%	100%	100%	100%
August	89%	73%	70%	89%	73%	70%
September	91%	73%	73%	90%	74%	70%
October	92%	77%	82%	91%	71%	76%
November	93%	79%	87%	93%	71%	80%
December	93%	80%	87%	94%	70%	81%
January	93%	80%	87%	95%	70%	87%
February	93%	80%	87%	95%	71%	87%

Flawless Execution Continued

4.0 FIT FOR THE FUTURE: WORKFORCE

4.1 Appraisal

Current Position (End of January) – 92.3% Overall. Target levels have been achieved in all BDU's and all are currently experiencing rates above 90% *(Barnsley 92.2%, Calderdale 93.9%, Forensics 93.1%, Kirklees 93.3%, Specialist Services 90.1%, Wakefield 91.2% and Support Services 92.3%)*

4.2 Sickness (End of January Position) – 4.76% Overall.

The current year to date absence rate for the whole of SWYPFT is 4.76%. This shows no change from last month's rate, but shows a significant reduction from last year's YTD rate of 5.29% in January2013.

The current 2013-14 (end of March 2014) projection is 4.79% which would be a 0.44% reduction from last year but would still be above the 4.0% Trust Board target. The current (YTD) SWYPFT absence rate has now seen slight month on month increases between the end of August through to January, though increases have been lower than projected and expected levels when factoring in seasonality of short term absence giving pressure to winter absence increases.

4.2.1 Current Year to Date (YTD) Sickness Absence Rates by BDU (End of January Position)

Barnsley BDU

- **Current YTD absence rate = 4.83%; Current projection by March 2014 = 4.79%; Projection Trend = Decreasing *(-0.01%)***
- Short term absence has been much reduced through winter months thus far in Barnsley BDU giving rise to a sustained lower projection of 4.79%.
- Hot spots include: Children's Services, Inpatient Rehabilitation, Long Term Conditions. The higher rates seen in these areas are due to long term absence which is being proactively managed (District Nursing currently accounting for 19.9% of ALL absence in the BDU and is currently part of targeted work with OH regarding long term stress related absence).

Calderdale BDU

- **Current YTD absence rate = 3.88%; Current projection by March 2014 = 3.75%; Projection Trend = Increasing *(+0.21%)***
- Calderdale continues to see the lowest rates across the Trust as a BDU. The last 4 months however have the seen the BDU see its highest absence due to short term seasonality and high absence within Substance Misuse at present. Absence rate in-month for January at 4.59% - reduced from 5.00% in December and 5.50% in November).
- BDU is still projecting a much lower rate than last year when it was 5.59% in January 2013. The BDU is on course to see an absence rate below 4% by March 2014.

Forensics BDU

- **Current YTD absence rate = 6.63%; Current projection by March 2014 = 6.62% Projection Trend = Increasing *(+0.07%)***
- Forensics continues to see higher absence rates than the rest of the Trust; the BDU has however made reductions from this time last year (7.23% cumulative in January and rising). The BDU has now seen month on month absence reduction in-month for 4

Flawless Execution Continued

months.

- The reduction overall is as a result of significant absence rate reductions in Medium Secure Services which sees the service enjoying their lowest rates for the past 3 years (5.52% cumulative). December and January saw the fewest number of on-going long term cases in the past 3 years also within Medium Secure.
- Long term absence is still being experienced in both Low Secure and Newhaven and this is causing high rates of 8.56% and 7.96% respectively. The reduction of absence in Medium Secure is the driving factor to keeping absence rates stable this year within Forensics.

Kirklees BDU

- **Current YTD absence rate = 5.31%; Current projection by March 2014 = 5.34%; Projection Trend = Increasing *(+0.04%)***
- The BDU has experienced the highest absence rates in the last 6 months – all nearly 1% higher than the previous 4 months.
- Older Peoples Services remains above target and has been rising since June 2013. The rate has been above 6.5% all year and has been above 7% for the past 4 months. This is mainly due to long term absence in specific areas which is being closely managed by both service leads and HR services.
- Ward 19 is the subject of a major service review including safer staffing levels as a result of sustained high absence which is causing cost pressures. Absence has remained above 10% within Nursing and Nursing support staff roles all year.

Specialist Services

- **Current YTD absence rate = 3.78%; Current projection by March 2014 = 3.60%; Projection Trend = Decreasing *(-0.43%)***
- The movement of Learning Disabilities staff from Barnsley BDU into Specialist Services (ESR) has led to a revised projection which is now even lower at 3.60%
- The BDU is seeing consistent absence rates around 4% since April. BDU overall cumulative absence is 1.54% lower than for the same period last year and is on target to see a rate below 4% by March 2014.
- 2 specific hot-spot areas within the Service account for over 27% of the total absence burden and these are being targeted (Fox View & Calderdale CDLT)

Support Services

- **Current YTD absence rate = 3.92% - Current projection by March 2014 = 3.98%; Projection Trend = Increasing *(-0.10%)***
- Overall, Support Services are currently meeting target levels and are projected to do so by April 2014 - the only area of higher absence is in Estates (5.09%YTD), however this rate is significantly lower than previous years where Estates staff had absence rates of 11-12%.

Wakefield BDU

- **Current YTD absence rate = 4.61%; Current projection by March 2014 = 4.60%; Projection Trend = Increasing *(-0.20%)***
- Cumulative absence rate has been slowly rising since May through to January, though the rate rise is not significant (3.9% in May to 4.6% in January). The BDU is still significantly reducing its absence rate from last year at the same point of the year (5.30% in January 2013). Current rate still sees the BDU experiencing its lowest BDU rate in the last 6 years.
- Increased projection to 4.60% as a result of increasing absence rates experienced in December and January (5.19% and 5.37% respectively)

- OPS seeing sustained lower absence throughout the winter months (YTD 3.64%). OPS absence rates are the reason why Wakefield is projected to reduce its overall rate by March 2014.

4.4.2 Summary:

- SWYFT overall rate has now risen for 6th month in a row, increase not as great as would be expected within winter months due to lower short term absence experienced.
- With the exception of Barnsley and Kirklees, all BDU's are projecting a lower absence rate by March 2014 than last year.
- Of the 33 services lines across the whole of SWYFT, 17 are currently achieving absence rates below 4% (no change from December).
- Stress continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4 to 5 days lost.
- The main reason for the revised overall projection increase in January is due to increases in long term absence in specific areas (Kirklees OPS, Newhaven and Low Secure in Forensics and Substance Misuse in Calderdale). Short term absence in Barnsley and Wakefield has been lower than forecasted over winter months which has prevented rate from rising sharply. Areas such as Medium Secure in Forensics.
- Reducing absence related to stress and reducing long term absence (currently accounts for approximately 75% of absence) are the main focus of BDU action plans and the Wellbeing Agenda with full support from OH.
- Calderdale, Specialist Services and Support Services BDU are projected to achieve the SWYFT target rate of 4% by the end of 2013-14 financial year.

4.3 Fire Training (March Position) – 79.9%: down from 81.5% last month

- Trust overall position is now 0.01% under target at 79.9% (target = 80%). This shows a reduction of 1.6% from last month.
- At present all BDU's have uptake levels between 73% and 85%. *(Barnsley 79.9%, Calderdale 76.8%, Forensics 84.7%, Kirklees 72.9%, Specialist Services 82.4%, Support Services 79.6%, Wakefield 83.9%).* The drop below 80% from December is as a result of uptake levels dropping in Calderdale (76.8% in March from 83.4% Feb), Specialist Services (82.4% in March from 87.4% in Feb) and Wakefield (83.9% in March from 87.2% in Feb).

4.4 Information Governance Training (Position as at 24th February) – 83.9% (Target – 95%). Up from 48.2%

- At present all BDU's have uptake levels between 76% and 90%. BDU current levels are as follows:
  1. *Barnsley **83.0%**: up from 72.9%,*
  2. *Calderdale **83.8%**: up from 67.3%,*
  3. *Forensics **90.1%**: up from 81.5%,*
  4. *Kirklees **87.4%**: up from 81.0%,*
  5. *Specialist Services **76.5%**: up from 71.4%,*
  6. *Support Services **82.6%**: up from 73.3%,*
  7. *Wakefield **85.6%**: up from 73.8%)*

4.4 Information Governance Training – (Position as at 17th March) 93%, (Target – 95%).

- In comparison to the same time last year the Trust had reached 75%, the end of month 11 position was 86% which evidences improved position.
- 895 staff completed their training in February, placing the Trust in a much better position to achieve the target by the end of March.
- Whilst less staff still need to complete the training in March than completed in either January or February, there are still 470 to complete in March.
- As at end of February, no directorate had reached the target. As at 17th March, Kirklees, Specialist Services and Wakefield BDU's had achieved 95% or above.
- Calderdale, Forensics, Kirklees and Wakefield BDUs have been successful in moving the bulk of their staff away from a last minute March completion date. This will make achieving the training requirement much easier next year.
- The number of staff who have avoided the training last year and so far this year has reduced from 109 at the beginning of April to 4 as at 17th March. Managers have been alerted to these staff in particular as they place the Trust at risk.

Glossary

AWA/WAA	Adults of Working Age
AWOL	Absent Without Leave
BDU	Business Delivery Unit
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Groups
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
EBITDA	Earnings Before Interest, Taxes, Depreciation and Amortization
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
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
Inf Prevent	Infection Prevention
KPIs	Key Performance Indicators
LD	Learning Disabilities
MAV	Management of Aggression and Violence
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-Resistant Staphylococcus Aureus
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
OH	Occupational Health
OPS	Older People’s Services
PbR	Payment by Results
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSA	Public Service Agreement
PTS	Post Traumatic Stress
ROA	Return On Assets
SIs	Serious Incidents
SU	Service Users
SWYT/SWYPFT	South West Yorkshire Partnership Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TBD	To Be Decided/Determined
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 11 2013 / 2014

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Overall Financial Position

Performance Indicator		Month 11 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					10	9	8		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	4	4 to 6
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	4	14
3	Capital Expenditure within 15% of plan.	●	●	⇩	●	●	●	4	16
4	In month delivery of recurrent CIPs	●	●	⇔	●	●	●	4	7 to 10
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	4	11
6	In month Better Payment Practice Code	●	●	⇩	●	●	●	4	18

Summary Financial Performance

1. The year to date position, as at February 2014 is showing a net surplus of £3.7m which is £0.1m marginally ahead of plan. The Forecast for the year remains consistent at £3.76m which is £0.043m marginally above plan.
2. At February 2014 the cash position is £32.8m which is £4.4m ahead of plan.
3. Capital spend to February 2014 is £6.36m which is £0.62m (9%) behind the revised capital plan.
4. At Month 11 the Cost Improvement Programme is £0.21m (approx 2%) under the target of £7.96m.
5. The Financial Risk Rating (Risk Assessment Rating) is 4 against a plan level of 4. A score of 4 is the highest possible.
6. As at 28th February 2014 (Month 11) 92% of NHS and 95% of non NHS invoices have achieved the 30 day payment target (95%).

Income & Expenditure

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(3,637)	(3,583)	54	Wakefield Commissioners	(40,002)	(39,515)	488	(43,639)	(43,416)	223
				(3,497)	(3,512)	(15)	Kirklees Commissioners	(38,074)	(37,886)	188	(41,571)	(41,389)	182
				(1,859)	(1,885)	(26)	Calderdale Commissioners	(20,068)	(19,924)	143	(21,927)	(21,794)	133
				(7,761)	(7,480)	281	Barnsley Commissioners	(80,863)	(80,166)	697	(88,159)	(87,673)	486
				(2,178)	(1,988)	190	Secure Services Comm's	(22,820)	(21,872)	948	(24,998)	(23,773)	1,225
				(42)	(73)	(31)	Non Contract Income	(358)	(585)	(228)	(388)	(618)	(230)
				(18,973)	**(18,521)**	**452**	**Total Income**	**(202,184)**	**(199,948)**	**2,236**	**(220,681)**	**(218,663)**	**2,018**
524	506	(19)	3.5%	1,839	1,924	85	Wakefield	20,081	20,344	262	21,906	22,216	310
599	575	(23)	3.9%	2,184	2,085	(99)	Kirklees	22,460	22,812	351	24,614	25,065	452
342	316	(26)	7.6%	1,188	1,204	17	Calderdale	12,424	12,597	173	13,617	13,790	173
1,636	1,519	(117)	7.2%	6,040	5,888	(153)	Barnsley	61,689	59,974	(1,715)	67,317	65,795	(1,522)
428	428	1	0.2%	1,370	1,367	(3)	Secure Services	14,897	15,021	124	16,268	16,392	125
413	384	(29)	7.1%	1,420	1,314	(106)	LD & Specialist	17,142	16,633	(509)	18,677	18,180	(498)
703	678	(24)	3.4%	3,570	3,316	(255)	Support	38,920	37,929	(990)	42,892	41,982	(910)
0	0	0		(614)	(1,107)	(493)	Provisions	3,276	2,074	(1,202)	3,441	2,066	(1,375)
4,644	**4,407**	**(238)**	**5.1%**	**16,997**	**15,991**	**(1,006)**	**Total Operating Expenses**	**190,890**	**187,384**	**(3,506)**	**208,732**	**205,487**	**(3,245)**
4,644	**4,407**	**(238)**		**(1,976)**	**(2,530)**	**(554)**	**EBITDA**	**(11,294)**	**(12,564)**	**(1,270)**	**(11,949)**	**(13,176)**	**(1,227)**
				446	417	(29)	Depreciation	4,908	4,769	(140)	5,354	5,214	(140)
				141	(16)	(157)	PDC Paid	1,556	1,399	(157)	1,698	1,526	(172)
				0	(7)	(7)	Interest Received	0	(80)	(80)	0	(85)	(85)
				782	2,363	1,581	Impairment of Assets	1,178	2,759	1,581	1,178	2,759	1,581
4,644	**4,407**	**(238)**	**5.1%**	**(607)**	**227**	**834**	**Surplus**	**(3,652)**	**(3,718)**	**(66)**	**(3,719)**	**(3,762)**	**(43)**

Income and Expenditure Summary

Forecast

The Trust annual plan surplus is £3.72m.

The forecast for the year end position, as at month 11, is that this target will be marginally exceeded by £43k and the key components of this are:

		£k	
*	Operational Budgets Position	1,870	Gain - Actual vs plan
*	Provisions	1,375	Provisions held to offset specific income risks
*	Depreciation	140	Gain - Actual vs plan
*	PDC	172	Gain - Actual vs plan
*	Interest better than planned	85	Gain - Increased cash balances
		3,642	
	Less:		
*	CQUIN Risk	579	
*	Activity Income Risk	1,439	
*	Revaluation Exercise	1,581	Includes Aberford Field timing delay
		3,599	
		43	Favourable

Forecast Risk and Mitigation

* The Trusts Estates Revaluation Exercise has been finalised in February 2014 and the full impact of this is shown within the February month 11 financial position. The actual impact of this is broadly in line with plan excepting the impact of the forecast revaluation of the Trust's land at Aberford Field. Planning consent has not been approved as per plan and is now expected in the first quarter of 2104 / 2015. As such the £1.3m revaluation beneift will not crystalise until this point. The impact of this transaction is to reduce the previously favourable variance to plan back to planned levels. This additional in year pressure has had to be managed within to ensure that the overall Trust financial position for 2013 / 2014 is obtained. This has been acheived to date by increased review and control of expenditure commitments whilst ensuring mininal or no impact on clinical services.
* Ongoing Restructuring Costs will be further reviewed as workforce plans are finalised as part of 2014 / 2015 business plans in March 2014. Additional requirements may be identified over the next few months as Transformation plans are further developed.

Month 11

The year to date position, as at month 11, reflects a £3.718m surplus which is £0.066m (2%) ahead of plan.

The principal components of this year to date surplus continue to be underspends in the Barnsley BDU, LD and Specialist Services, and in the Support Directorates.

These underspends are due to cost commitment review and expenditure management.

In contrast the Calderdale and Kirklees BDU's are showing continuing overspends, against plan, mainly on out of area expenditure and expenditure on bank staff. This pressures remain and action needs to be taken to ensure that this does not present a financial risk for 2014 / 2015.

Income and Expenditure Detail

Healthcare Contract Income

Income is behind plan. This is due to:

* The shortfall against CQUIN income in Quarter 1,2 & 3 is £336k against a budget of £3.5m. (10%) Quarter 4 performance continues to be monitored and will require agreement with Commissioners.

* Barnsley BDU is not able to recover planned (budgeted) income arising from available PICU beds and Substance Misuse. These are under plan by £0.24m year to date.

* Non recurrent support from Wakefield CCG (revised to £600k) is being finalised with Commissioners and will be reflected in the month 12 financial position.

The CQUIN income target for 2013/2014 is £4.7m. The current position assumes a current shortfall of £579k to target. CQUIN performance continues to be managed through the monthly Executive performance review and reported to Trust board.

BDU Operational Income & Expenditure

The key factors in the expenditure position are considered below:

* Wakefield BDU - The year to date position is £262k overspent. This is a £85k increase in overspend from Month 10. The forecast overspend position is £310k which is a £59k increase from Month 10.This movement relates to additional Out of Area expenditure.

* Kirklees BDU - The year to date position is £351k overspent. This is a £99k reduction in overspend from Month 10. The forecast overspend position is £452k which is a £43k reduction from Month 10.

* Calderdale BDU - The year to date position is £173k overspent. This is a £17k increase in the overspend position from Month 10. The forecast overspend position is £173k which an increased overspend from previous forecasts.

* Barnsley BDU - The year to date position is £1715K underspent. This is a £256k increased underspend from Month 10. The forecast underspend has remained broadly static at £1522k.

* LD & Specialist - The year to date position is £509k underspend. This is a £2k increase in the underspend position from Month 10. A high level of vacancies remain within these areas.The forecast underspend is £498k which is a reduction of £47k due to additional agency medical costs to provide maternity / sickness cover.

* Secure Services - The year to date position is £124k overspent. This is a £3k reduced overspend position from Month 10. The forecast position remains the same.

* Support - The year to date position shows a £255k increase of the underspend position to £990k underspent. The forecast has been revised to reflect current assumptions and presents an underspend position of £910k.

Summary Performance of Cost Improvement Programme

Delivery of Recurrent Savings 2013 / 2014

Recurrent 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	46	46	46	46	46	46	46	46	46	46	46	46	506	552
	Actual	36	36	36	36	27	25	25	25	33	35	35		348	383
	Variance	(10)	(10)	(10)	(10)	(19)	(21)	(21)	(21)	(13)	(11)	(11)		(158)	(169)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	264	288
	Actual	24	24	24	24	24	22	17	17	17	17	17		225	242
	Variance	0	0	0	0	0	(3)	(7)	(7)	(7)	(7)	(7)		(39)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	515	570
	Actual	25	25	25	25	25	25	25	25	25	25	25		276	301
	Variance	0	0	0	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)		(239)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	356	393
	Actual	20	20	20	19	19	19	19	19	19	19	19		210	229
	Variance	0	0	0	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(18)		(146)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	424	463
	Actual	27	27	27	27	27	28	28	28	28	28	28		305	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)		(119)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,725	1,882
	Actual	134	134	135	135	135	135	135	135	135	135	135		1,480	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)		(245)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,386	1,512
	Actual	115	115	115	104	109	114	111	111	111	89	89		1,184	1,274
	Variance	(11)	(11)	(11)	(22)	(17)	(12)	(15)	(15)	(15)	(37)	(37)		(202)	(238)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,783	3,035
	Actual	253	253	253	253	253	253	253	253	253	253	253		2,783	2,535
	Variance	0	0	0	0	0	0	0	0	0	0	0		0	(500)
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	7,959	8,695
	Actual	634	634	635	623	620	620	612	612	620	601	601		6,811	6,911
	Variance	(54)	(54)	(54)	(113)	(116)	(117)	(125)	(125)	(117)	(136)	(136)		(1,148)	(1,784)

Summary Performance of Cost Improvement Programme

Mitigation of CIP Shortfall 2013 / 2014

Recurrent 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													0	0
	Actual	9	9	9	9	9	11	10	10	7	3	3		89	91
	Variance	9	9	9	9	9	11	10	10	7	3	3		89	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6	6	6	6	6	6		40	46
	Variance	0	0	0	1	1	6	6	6	6	6	6		40	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23	57	103	75	4	4		265	269
	Variance	0	0	0	0	0	23	57	103	75	4	4		265	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	1	1	36	16	22	22	22	22		142	164
	Variance	0	0	0	1	1	36	16	22	22	22	22		142	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0	8	8		15	23
	Variance	0	0	0	0	0	0	0	0	0	8	8		15	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22	22	22	22	22	22		245	267
	Variance	22	22	22	22	22	22	22	22	22	22	22		245	267
Support	Target													0	0
	Actual	9	9	9	20	15	9	15	15	15	15	15		144	159
	Variance	9	9	9	20	15	9	15	15	15	15	15		144	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0		0	500
	Variance	0	0	0	0	0	0	0	0	0	0	0		0	500
Total	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	40	40	40	53	48	107	127	178	147	80	80		940	1,520
	Variance	40	40	40	53	48	107	127	178	147	80	80		940	1,520

Summary Performance of Cost Improvement Programme

Total CIP Programme 2013 / 2014

Recurrent 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	46	46	46	46	46	46	46	46	46	46	46	46	506	552
	Actual	45	45	45	45	36	36	35	35	40	38	38	0	437	475
	Variance	(1)	(1)	(1)	(1)	(10)	(10)	(11)	(11)	(6)	(8)	(8)		(69)	(77)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	264	288
	Actual	24	24	24	25	25	27	23	23	23	23	23	0	265	288
	Variance	0	0	0	1	1	3	(1)	(1)	(1)	(1)	(1)		1	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	515	570
	Actual	25	25	25	25	25	48	82	128	100	29	29	0	541	570
	Variance	0	0	0	(30)	(30)	(7)	27	73	45	(26)	(26)		26	(0)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	356	393
	Actual	20	20	20	20	20	54	35	41	41	41	41	0	352	393
	Variance	0	0	0	(17)	(17)	17	(2)	4	4	4	4		(4)	(0)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	424	463
	Actual	27	27	27	27	27	28	28	28	28	36	36	0	320	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(3)	(3)		(104)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,725	1,882
	Actual	156	156	157	157	157	157	157	157	157	157	157	0	1,725	1,882
	Variance	0	0	0	0	0	0	0	0	0	0	0		0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,386	1,512
	Actual	124	124	124	124	124	123	125	125	125	105	105	0	1,328	1,433
	Variance	(2)	(2)	(2)	(2)	(2)	(3)	(1)	(1)	(1)	(21)	(21)		(58)	(79)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,783	3,035
	Actual	253	253	253	253	253	253	253	253	253	253	253	0	2,783	3,035
	Variance	0	0	0	0	0	0	0	0	0	0	0		0	0
Total	**Target**	**688**	**688**	**689**	**736**	**736**	**737**	**737**	**737**	**737**	**737**	**737**	**736**	**7,959**	**8,695**
	Actual	**674**	**674**	**675**	**676**	**668**	**727**	**739**	**790**	**767**	**681**	**681**		**7,751**	**8,431**
	Variance	(14)	(14)	(14)	(60)	(68)	(10)	2	53	30	(56)	(56)		(208)	(264)

Delivery of Cost Improvement Plans

Delivery of Cost Improvement Programme

Forecast

The table on page 7 illustrates the delivery of the recurrent cost improvement programme for 2013 / 2014. The table on page 8 shows the value of non-recurrent substitutions identified by BDU's and the net overall position is shown on page 9.

The impacts of the Cost Improvement Programme are fully reflected in the Income & Expenditure position noted above.

The overall Trust target is £8.7m. The latest forecast is achievement of £6.91m recurrently, a shortfall of £1.78m. A total of £1.52m is expected to be managed by recurrent and non-recurrent measures in year.

The main elements of the shortfall against the original plan are:	£k
* Rehab & Recovery (Trustwide)	500
* E-Rostering (Kirklees & Calderdale)	433
* Additional target (Barnsley BDU)	267

Month 11 Position

The year to date target is £7.96m and to date BDU's have allocated £7.75m. This leaves a shortfall of £208k.

* Wakefield BDU - the year to date position reflects slippage of 1 scheme, this is £69k. Overall the total forecast shortfall is £77k and a further substitution needs to be identified to resolve this.

* LD & Specialist - A number of schemes have slipped, totalling a forecast of £46k. These have been met with non recurrent substitutions.

* Kirklees BDU - The year to date position reflects the amendment of the original e-rostering scheme (£269k) to a number of different recurrent and non recurrent mitigations. The BDU need to finalise plans for all of these to be delivered recurrently.

* Calderdale BDU - The year to date position reflects the amendment of the original e-rostering scheme (£164k) to a number of different recurrent mitigations.

* Secure Services - The year date position is £119k under plan with a forecast of £130k. Forecast substitutions total £23k which leaves a shortfall of £107k still to be identified.

* Barnsley BDU - The recurrent year to date position is £245k under plan and forecast to be £267k under plan. This shortfall is being met by non recurrent savings identified in a number of areas such as drugs and Community equipment. Recurrent plans continue to be developed.

* Support - The year to date position is £202k due to delays in realising procurement CIP's and expected delays in recruitment. The forecast position is a shortfall of £238k and with the exception of the procurement CIP non recurrent substitutions are being found.

* Trustwide - The annual plan contained an assumption around the delivery of a Trustwide Rehab & Recovery CIP. It is now forecast that this will not be achieved. As part of the Transformation programme it needs to be validated if this can be delivered in 2014 / 2015. This is mitigated through provisions.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	February 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	9.8	4	5.8	4
Liquidity	18.8	4	12.8	4
Weighted Average		**4**		**4**

Financial Risk Rating 2013/ 2014

	February 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.73%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.74%	5	5.70%	5
I&E surplus margin	2.79%	4	2.40%	4
Liquid ratio	32.6	4	27.9	4
Weighted Average		**4.1**		**4.1**

The introduction of the Risk Assessment Framework in October 2013 means that the Trust financial rating, the Continuity of Service Risk Rating, is now based upon 2 metrics.

Both of these are currently better than planned.

These are rated on a scale of 1 - 4 with 4 being the highest possible score.

We will continue to monitor the previous ratings in shadow form for the immediate future.

The Monitor Financial Risk Rating is 4.1 against a planned position at the end of Quarter 4 2013 / 2014 of 4.1.

All 5 metrics are better than planned.

Monitor Benchmarking

All Foundation Trusts

Continuity	Governance Rating: No Evident Concerns	Issues Identified	Enforcement Action	Total
4	**81**	6	9	**96**
3	23	2	4	**29**
2	4	5	6	**15**
1	0	0	7	**7**
Total	**108**	**13**	**26**	**147**

Mental Health Trusts

Continuity	Governance Rating: No Evident Concerns	Issues Identified	Enforcement Action	Total
4	**27**	2	2	**31**
3	9	0	0	**9**
2	1	0	0	**1**
1	0	0	0	**0**
Total	**37**	**2**	**2**	**41**

The table to the left shows overall performance by the 147 Foundation Trusts (monitored by Monitor) for the 9 months to the end of December 2013 (Quarter 3). Of these 41 are Mental Health Trusts.

Quarter 3 represents the first Quarter under the new Risk Assessment Framework.

The majority of Trusts, and 75% of Mental Health Trusts, obtain a Continuity of Service of 4 presenting a strong current financial position.

Within the overall Foundation Trust sector it is noted that 32 Trusts undertook asset impairments in Q3 and 29 identified restructuring costs. SWYPFT is included within these figures.

Analysis of Expenditure by Type 2013 / 2014

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(8.25)	(7.58)	(7.73)	(0.15)	
	Recharges	(5.41)	(5.05)	(5.19)	(0.14)	
Non-healthcare Income Total		(13.66)	(12.63)	(12.91)	(0.29)	
	Admin & Clerical	27.54	25.11	24.24	(0.87)	1
	Agency	2.68	2.47	3.20	0.74	2
	Ancillary	7.17	6.57	6.44	(0.14)	
	Medical	19.60	17.95	17.25	(0.70)	1
	Nursing	83.04	76.14	73.57	(2.57)	1
	Other Healthcare Staff	33.03	30.30	27.81	(2.49)	1
	Other Pay Costs	(4.47)	(4.22)	0.00	4.22	3
	Senior Management	1.42	1.31	1.17	(0.13)	
	Social Care Staff	2.48	2.28	2.22	(0.06)	
Pay- Expenditure Total		172.50	157.90	155.91	(2.00)	
	Clinical Supplies	2.72	2.49	2.41	(0.08)	
	Drugs	4.33	3.97	3.75	(0.22)	
	Healthcare subcontracting	2.95	2.71	3.81	1.11	
	Hotel Services	2.46	2.27	2.29	0.03	
	Office Supplies	4.21	3.71	3.56	(0.16)	
	Other Costs	6.14	5.46	5.38	(0.08)	
	Property Costs	6.73	6.25	6.63	0.38	
	Service Level Agreements	5.90	5.38	5.40	0.02	
	Training & Education	1.45	1.32	0.79	(0.52)	
	Travel & Subsistence	5.76	5.32	4.60	(0.72)	
	Utilities	2.03	1.83	1.76	(0.07)	
	Vehicle Costs	1.78	1.65	1.93	0.28	
Non-pay Expenditure Total		46.45	42.34	42.32	(0.02)	
	Provisions	3.44	3.28	2.07	(1.20)	
Grand Total		**208.73**	**190.89**	**187.38**	**(3.51)**	

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

This subjective analysis supports the I & E analysis.

* There is a £6.96m underspend on pay. This is being offset by the £4.22m staff vacancy factor and £0.74m agency overspend.

* Non pay shows relatively small variances over a number of categories. The most significant is Healthcare Subcontracting which includes the out of area spending relating to PICU and acute beds.

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.

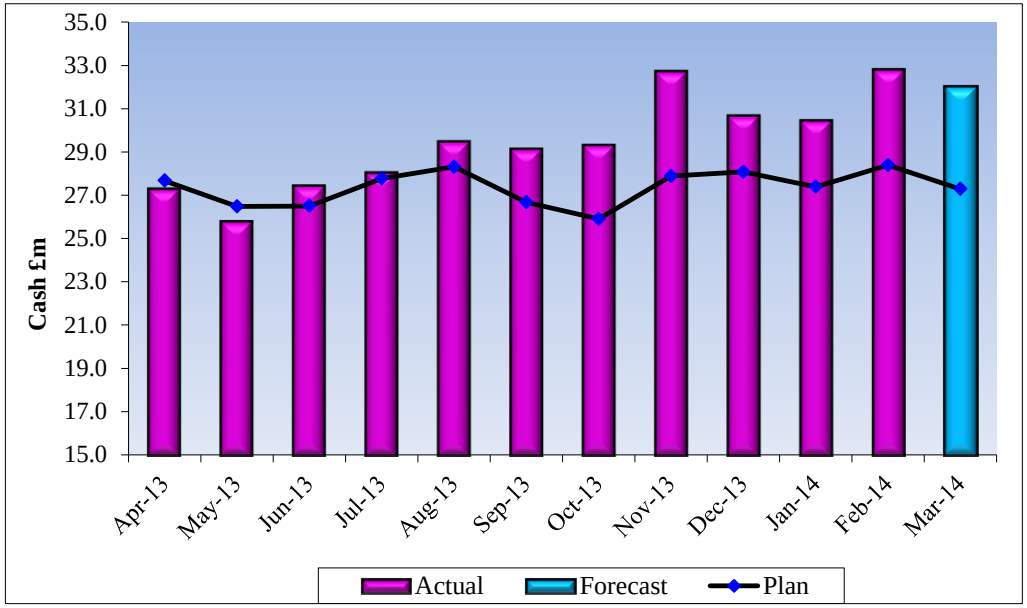
2. Agency costs are higher than planned. Spend is:

* Medical £1049k
* Nursing £673k
* Scientific & PAMs £578k
* Admin & Clerical £901k

This is external agency costs only

3. This represents the recurrent staff vacancy factor. The savings requirement is £4.47m across the Trust and is planned to be acheived.

Cash Flow Forecast 2013 / 2014



The graph to the left shows the cash flow forecast position, at the end of the month, for 2013 / 2014.

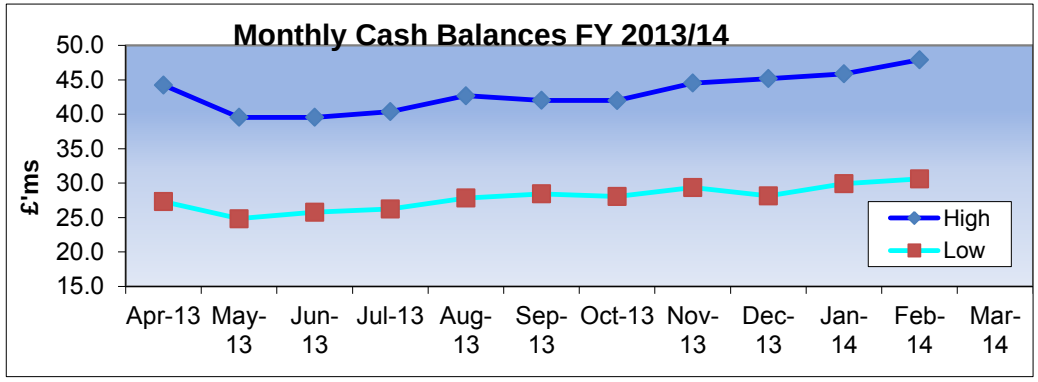
The plan is based upon the Annual Plan submitted to Monitor in May 2013.

The actual cash position for the month is £32.81m. This is £4.42m ahead of the planned cash value of £28.39m.

A breakdown of this movement is provided on page 15 as the Reconciliation of actual cash flow to plan.

Overall the forecast is that cash will be better than planned during 2013 / 2014 due to the cash implications arising from the delayed capital plan position.

	Plan	Actual
	£m	£m
Opening Balance	27.39	30.46
Closing Balance	28.39	32.81



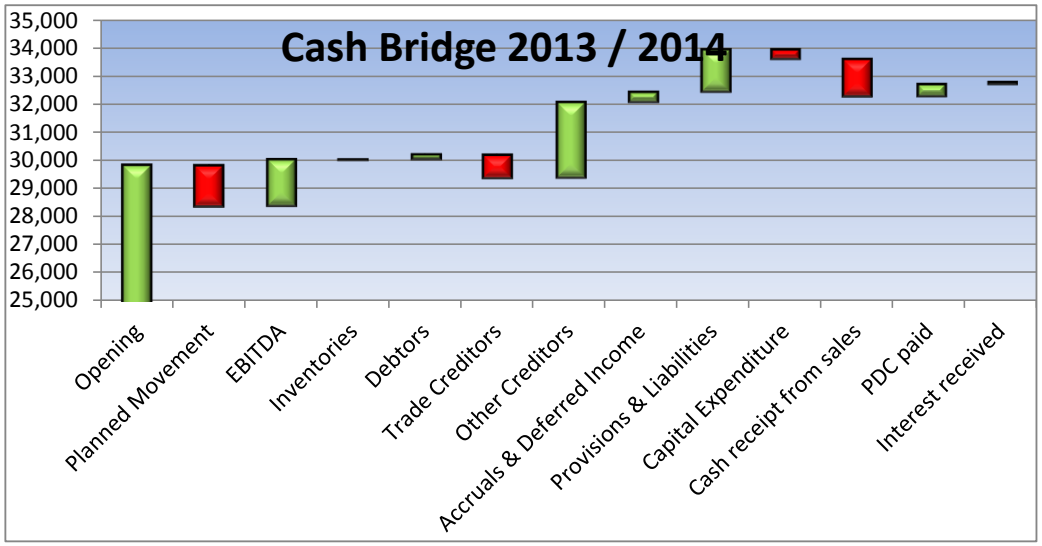
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £47.91m.
The lowest balance is : £30.63m.

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

Reconciliation of Actual Cash Flow to Plan

	LTFM Plan £m	Actual £m	Variance £m	Note
Opening Balances	**29.85**	**29.85**	**0.00**	
EBITDA (Exc. non-cash items & revaluation)	10.89	12.56	**1.67**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(3.38)	(3.21)	**0.17**	*3*
Trade Payables (Creditors)	0.62	(0.21)	**(0.83)**	
Other Payables (Creditors)	(1.64)	1.05	**2.69**	
Accruals & Deferred income	0.39	0.76	**0.37**	*2*
Provisions & Liabilities	(3.38)	(1.87)	**1.51**	
Movement in LT Receivables				
Capital expenditure	(5.16)	(5.50)	**(0.34)**	*4*
Cash receipts from asset sales	1.33	0.00	**(1.33)**	*4*
PDC Dividends paid	(1.13)	(0.70)	**0.43**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.08	**0.08**	
Closing Balances	**28.39**	**32.81**	**4.42**	



The Annual Plan reflects the May 2013 submission to Monitor.

Factors which increase the cash position against plan:

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

2. The value of accruals continue to be higher than planned and are monitored.

3. Debtors continue to be managed and payment is being secured. At month 11 no material debtors issues have been noted.

4. Creditors are higher than planned and the majority relates to a charge for LIFT properties dating back to April 2014 only just received. (c.£1.9m)

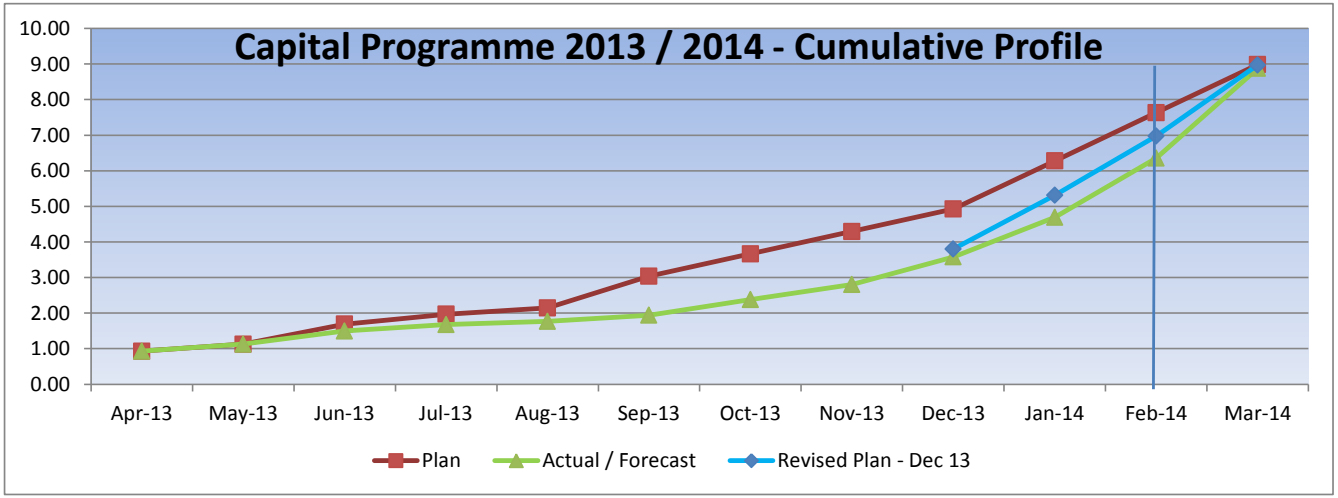
Factors which decrease the cash position against the plan:

4. The capital programme, and proposed sale of Aberford Field, have a negative impact on the cash postion when compared to plan.

The cash bridge to the left depicts , by heading, the positive and negative impacts on the cash position throughout the course of the year. This has been updated and now reflects the movement as compared to plan.

Capital Programme 2013 / 2014

Capital Expenditure Plans - Application of funds	Scheme Total £m	REVISED Annual Budget £m	REVISED Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Actual £m	Forecast Variance £m	Note
Maintenance (Minor) Capital								
Small Schemes	4.89	4.12	3.21	2.78	(0.43)	4.45	0.33	
Total Minor Capital		**4.12**	**3.21**	**2.78**	**(0.43)**	**4.45**	**0.33**	*2*
Major Capital Schemes								
Newton Lodge	11.80	1.31	1.31	1.32	0.00	1.32	0.00	
IM&T	1.60	0.85	0.43	0.23	(0.20)	0.65	(0.20)	
Estate Strategy	19.90	2.84	2.13	2.06	(0.07)	2.59	(0.24)	
Total Major Schemes		**5.00**	**3.87**	**3.60**	**(0.27)**	**4.56**	**(0.44)**	*3*
VAT Refunds		(0.13)	(0.11)	(0.02)	0.08	(0.13)	0.01	
TOTALS		**8.99**	**6.98**	**6.36**	**(0.62)**	**8.88**	**(0.11)**	*1*



Capital Expenditure 2013 / 2014

1. The total Capital Programme for 2013 / 2014 is £8.99m.

2. The year to date position is £0.62m under plan (9%) when compared to the resubmitted plan of December 2013.
This is due to amendments within the seclusion room and CES decontamination unit projects. There has also been delays experienced within the Dales and major Utility upgrade projects. Overall these remain forecast to be delivered as planned.

3. The forecast position assumes £2.5m of expenditure in March 2014 and the Capital Team continue to ensure that this is delivered.

4. The main schemes spend in Qtr 4 relate to:

Forensic Ward Refurbishment	£1.55m
Seclusion Facilities	£0.55m
Major Utilities Upgrade	£0.83m
Calderdale Hub	£0.35m
Total	**£3.28m**

5. Each scheme has been reviewed and delivery assessed. The current forecast assumes that projects will be delivered as planned and therefore events, such as changes in the weather, may provide a risk to this forecast.

Balance Sheet

	Actual at 31/03/13	Plan at 28/02/14	Actual at 28/02/14	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**109.49**	**101.69**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.56	
NHS Trade Receivables (Debtors)	1.43	3.04	1.94	*2*
Other Receivables (Debtors)	3.15	5.06	5.85	*3*
Cash and Cash Equivalents	29.85	28.39	32.81	*9*
Total Current Assets	**34.99**	**37.05**	**41.16**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(3.10)	(2.27)	*4*
Non NHS Trade Payables (Creditors)	(3.88)	(2.64)	(5.07)	*4*
Other Payables (Creditors)	(3.36)	(3.50)	(3.92)	
Capital Payables (Creditors)	(1.25)	(0.85)	(2.28)	*5*
Accruals	(9.03)	(10.22)	(9.09)	*6*
Deferred Income	(0.79)	(0.93)	(1.48)	
Total Current Liabilities	**(20.79)**	**(21.24)**	**(24.11)**	
Net Current Assets/Liabilities	**14.20**	**15.81**	**17.04**	
Total Assets less Current Liabilities	**83.40**	**125.30**	**118.73**	
Provisions for Liabilities	(8.07)	(4.69)	(6.20)	*7*
Total Net Assets/(Liabilities)	**75.33**	**120.61**	**112.53**	
Taxpayers' Equity				
Public Dividend Capital	(41.99)	(41.99)	(43.40)	
Revaluation Reserve	(7.26)	(22.54)	(14.50)	
Other Reserves	(5.22)	(5.22)	(5.22)	
Income & Expenditure Reserve	(20.86)	(50.86)	(49.41)	*8*
Total Taxpayers' Equity	**(75.33)**	**(120.61)**	**(112.53)**	

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

1. Fixed assets include the April 2013 transfer of Estate from Barnsley (£37.9m). The plan value is reflective of the original capital programme.

2. NHS debtors are £1.94m which is £1.1m lower than plan. This is due to improvements in invoicing and cash flow actioned in year and lessons from this have been included in the plan profile for 2014 / 2015.

3. Other debtors are higher than planned. Timily payments from our Council Commissioners continue to be chased.

4. Creditors continue to be managed in year. The biggest elements are Superannuation, income tax and National Insurance which are all paid monthly in arrears.

5. Capital payables are higher than planned due to the changes made to the Capital programme.

6. Accruals are lower than planned. Approx £2m reduction is due to an invoice dating back to April 2013 now being received. (And is reflected as a creditor)

7. Payments against provisions have continued to be made under different timescales than planned.

8. These represent year to date surplus plus reserves brought forward.

9. The Reconciliation of Actual Cash Flow to Plan compares the current month end cash position to the LTFM forecast for the same period.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to January 2014	92.2%	92.7%
Year to February 2014	92.3%	92.9%

Non NHS		
	Number	Value
	%	%
Year to January 2014	95.1%	92.4%
Year to February 2014	95.0%	92.6%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to January 2014	74.3%	66.7%
Year to February 2014	74.8%	67.5%

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

The performance against target for NHS invoices is 92% of the total number of invoices that have been paid within 30 days and 93% by the value of invoices.

The performance against target for Non NHS invoices is 95% of the total number of invoices that have been paid within 30 days and 93% by the value of invoices.

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

To date the Trust has paid 75% of Local Supplier invoices by volume and 67% by the value of invoices 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 (£)
26/02/2014	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8108122	196,254
19/11/2013	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2150739	36,992
24/01/2014	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2154611	48,900
27/01/2014	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2154682	104,987
27/01/2014	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2154670	52,350
27/01/2014	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2154650	99,559
28/01/2014	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2154731	55,694
06/02/2014	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2155220	102,362
18/02/2014	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2156034	106,522
21/02/2014	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2156237	50,007

Glossary of Terms & Definitions

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

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.
* Forecast Surplus - This is the surplus we expect to make for the financial year
* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to achieve breakeven.
* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not pat of the Recurrent Underlying Surplus.
* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.
* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. This Trust has historically only approved recurrent CIP's. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.
* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.
* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 7.3(i)

Title:	**Update on Information Governance 2013/14**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	To advise Trust Board of the Trust's position in relation to information governance as at March 2014
Vision/goals:	Information governance is a key issue for patient safety and for the Trust's reputation.
Any background papers/ previously considered by:	Information Governance annual report to the Clinical Governance and Safety committee 11 February 2014
Executive summary:	Information Governance Toolkit self-assessed scores are submitted annually. This paper updates Trust Board on the Trust's position. It provides a summary of the scores and details of information governance serious incidents requiring investigation (SIRIs) which have occurred during the year. The scores are provisional at this time. Each of the 45 standards has four possible levels of achievement (0,1,2,3). Trusts are expected to achieve at least level 2 on each standard. There are three standards where the Trust expects to reach level 3 and the remainder level 2, although there is still some outstanding work to do. As part of its information governance responsibilities, the Trust is required to ensure that at least 95% of its staff complete information governance training annually. The Trust position at 17 March 2014 is 93% with approximately 300 staff still required to complete the training by the 31 March 2014. This position is much improved from the same time last year (75%). Approximately 300 staff are excluded from the figures due to maternity leave, long term sickness and other reasons. At the beginning of January 2014, there were 93 staff who had not completed the training last year or so far this year. Due to direct targeting of these staff, this position has improved to 42.

	Area	**2012/13**	**Potential Score March 2014**
1	Information Governance Management	(green) 73%	(green) 66%
2	Data Protection and Confidentiality Assurance	(green) 77%	(green) 70%
3	IT Security	(green) 68%	(green) 68%
4	Clinical Information Assurance	(green) 66%	(green) 66%
5	Secondary User Assurance	(green) 66%	(green) 66%
6	Corporate Information Assurance	(green) 77%	(green) 77%
	Overall	**(green) 71%**	**(green) 71%**

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

	Changes in 2013/14 Guidance was issued in June 2013 requiring the Trust to report any incidents scoring level 2 or above externally to the Health and Social Care Information Centre (HSCIC) and the Information Commissioners Office (ICO). The scoring criteria takes into account the number of people affected but also they type of incident and the sensitivity of the information. A new method of scoring was included with this guidance. This means that incidents which previously would not have been reported are now reported externally. The new scoring method means that the misdirection or loss of one person's clinical information, where it relates to mental health, or children, or a sensitive condition may meet the criteria to be reported externally. At the current time three incidents have been reported as meeting the threshold for external reporting, under the new reporting requirements. Two of these, which occurred in Wakefield CAMHS, are being followed up by the ICO and could result in enforcement action or a fine. Another incident where a letter with sensitive information was wrongly addressed may also be a level 2 score. There were two level 1 incidents. Under the previous reporting criteria for the period January to July there were three level 1 incidents and one level 2 incident. The Trust was not required to report these externally In all 299 incidents were reported internally in 2013/14.
Recommendation:	**Trust Board is asked to note the position in relation to Information Governance and approve the submission of the Toolkit outcome for 2013/14.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 7.3(ii)

Title:	**Eliminating mixed sex accommodation – Trust compliance statement**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	To appraise the Board of the Trust position in relation to EMSA and approve the declaration.
Vision/goals:	Develop our services to meet local expectations, be the service of choice for service users
Any background papers/ previously considered by:	Trust Board has previously reviewed the compliance statement annually. Any exception reports regarding EMSA are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing. There have been no exception reports in 2013/14.
Executive summary:	**Background** This paper informs Trust Board of the organisation's level of compliance with the national standard in respect of eliminating mixed sex accommodation (EMSA). The declaration of compliance, which will appear on the Trust's website, is below. The Trust is expected to make a declaration to commissioners by 31 March 2014 to confirm the Trust's position regarding compliance with the EMSA standard. The Trust is then required to post its statement of compliance on its Trust website. The guidance in relation to EMSA expects Trusts to provide single sex accommodation, which can be provided in: • single sex wards (the whole ward is occupied by men or women but not both); • single rooms with adjacent single sex toilet and washing facilities; • single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room. In addition service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own. **Current Trust position** During 2013 there have been no reported EMSA breaches. Results from the 2013 EMSA best practice audit confirm 100% compliance with the standards related to sleeping accommodation and toilet/washing facilities. Toilet and bathroom facilities are gender specific (or can be designated as such) and service users do not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own facilities. Women-only lounges or rooms which can be designated as such are available. The Trust is, therefore, in a position to once again declare EMSA compliance as follows. *"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire*

	Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable. *"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."* **Compliance monitoring** The Clinical Governance and Clinical Safety Committee receives assurance through the Director of Nursing about the Trust's compliance with EMSA. Any potential areas of risk are considered at quarterly EMSA review group meetings. During 2013 the EMSA review group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2013 there were 55 such instances reported on Datix compared with 51 for the same time period in 2012. The 2013 EMSA Best Practice Guidance Audit Report indicates that the Trust continues to perform well against best practice standards. The EMSA review group will implement action against any areas where improvements can be made. The Trust also has an action plan for continued monitoring and improvement, which is linked to the Patient-led Assessment of the Care Environment (PLACE) formally known as (PEAT). Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made. Currently the Trust is completing a major refurbishment programme in respect of seclusion facilities. **Financial implications** Non-compliance of the EMSA standard is a 'nationally specified event'. An EMSA breach will continue to carry financial penalties.
Recommendation:	**Trust Board is asked to APPROVE the compliance declaration.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 8.2

Title:	**Annual Governance Statement 2013/14**
Paper prepared by:	Chief Executive
Purpose:	The purpose of the paper is to seek Trust Board support for the Annual Governance Statement, which will be included in the annual report and accounts for 2013/14 and will be subject to independent audit by Deloitte as part of this process.
Vision/goals:	A sound system of internal control supports the Trust's governance arrangements.
Any background papers/ previously considered by:	Guidance on completing the Annual Governance Statement is included in Monitor's Annual Reporting Manual and is based on Treasury requirements.
Executive summary:	All NHS organisations are required to have risk management, control and review processes in place, appropriate to their circumstances and business. All Foundation Trusts have to produce an Annual Governance Statement (AGS), which is included in the organisation's annual report and accounts and is externally audited, covering : - scope of responsibility; - the purpose of the system of internal control; - capacity to handle risk; - the risk and control framework; - review of economy, efficiency and effectiveness of the use of resources; - annual Quality Report; - review of effectiveness; - conclusion. Foundation Trusts are required to make disclosures or qualifications in the AGS about their risk management and review processes being in place for the full year, and gaps in assurance frameworks. The AGS must contain statements on compliance with and assessment against specified requirements and significant control issues for 2013/14. Organisations should ensure that they have evidence which they deem sufficient to demonstrate that they have implemented processes appropriate to their circumstances under each of the high level elements to support their AGS for 2013/14. The AGS has been produced in accordance with current guidance from Monitor. The Trust is required to include the narrative in red in the Statement by Monitor as this follows HM Treasury guidance. The items highlighted in yellow will require updated narrative or an updated figure at the year-end and will be updated prior to presentation to the Audit Committee in May 2014.
Recommendation:	**Trust Board is asked to approve the Annual Governance Statement for 2013/14.** Trust Board should note that the Statement may be subject to change following review by Deloitte as part of the audit of the Trust's annual

	report and accounts. As a consequence, **Trust Board is asked to delegate authority to the Audit Committee to approve a final version of the Statement as part of its approval of the annual report and accounts on 23 May 2014, if necessary.** The final version of the statement will be brought back to Trust Board in June 2014 as part of Trust Board's consideration of the annual report and accounts.
Private session:	Not applicable

Annual Governance Statement 2013/14

Scope of responsibility

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

My Annual Governance Statement reflects the challenges and changes that have faced the Trust over the past year. The complexity and diversity of the services the Trust provides and the geography it covers presents a unique challenge, which is reflected in the Trust's approach to the management of risk. I would particularly like to highlight two areas.

The Trust took the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry findings extremely seriously and must integrate the recommendations with the findings from other national reports, such as Winterbourne View, and work to enhance, not reinvent, governance processes. The response taken, therefore, has been an appropriately measured one and, wherever possible, proposed action has been integrated with existing and planned organisational processes. The Trust has established a Director-level group to oversee the work to address Francis actions involving the Directors of Nursing, Human Resources and Workforce Development, and Corporate Development and the Medical Director. The group is supported by the 'Francis into Action' group, with cross-Trust representation and led by the Director of Nursing, to ensure actions are implemented within and across the Trust's services. The Trust also received substantial assurance from internal audit on its arrangements for responding to the Report's recommendations.

This year has also seen the consolidation of the integration of services that transferred to the Trust in Barnsley, Calderdale and Wakefield. The Trust has also seen children's and adolescent's mental health services (CAMHS) transfer in Calderdale and Kirklees, and Barnsley. As a result, the Trust now provides CAMHS across its four districts; however, the transfers have not been without risk and the Trust has robust arrangements in place to address the inherited risks presented around leadership and reputation and to ensure improvements are made to service delivery. This will continue to be an area of risk for the Trust in 2014/15.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

One of the strengths of the Trust is the stability of its Board. During the year, the Chair has continued to consolidate the changes to Trust Board to improve its effectiveness. The Members' Council approved the re-appointment of one non-executive director for a further three-year term and has devolved responsibility to the Nominations Committee to oversee and manage the process to appoint a replacement for another non-executive director, who will leave Trust Board in May 2014 following completion of two three-year terms of office.

One of the considerations for the Nominations Committee is to ensure effective succession planning. As a result, the Committee supported the Chair's view that the process should focus on recruiting an individual who could replace the current Chair of the Audit Committee, who will leave office in 2015. The recruitment process has now begun and the Committee took the decision to commission an external recruitment consultant to manage the process to ensure openness and transparency. A recommendation for appointment will be made by the Committee to the full Members' Council in April 2014.

To address two potential areas of risk, Trust Board has established two non-executive director-led forums for estates and information management and technology. The purpose of both groups is to ensure the Trust's strategy is developed and implemented, and that risk is managed effectively.

In July 2013, the Trust's District Service Director for Calderdale and Kirklees left the Trust to take a post at Calderdale and Huddersfield NHS Foundation Trust. Although this presented a risk in terms of leadership and management of both Business Delivery Units (BDUs), it provided an opportunity to review and consolidate the senior level structure for all four locality-based BDUs to support the transformation programme. As Chief Executive and in consultation with the Chair of the Trust, I put arrangements in place to utilise the skills and experience of two existing Directors to ensure strong and effective strategic and operational management within each BDU whilst maintaining a strong local focus.

As a result, there are now three BDU Directors leading and managing Calderdale and Kirklees BDUs, with specialist services, Barnsley and Wakefield BDUs, and forensic services. This has enabled a stronger management structure to be developed for each BDU with the appointment of deputy directors providing operational leadership and management. This will allow BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. This will be supported by arrangements at service line level where a clinical lead, general manager and practice governance coach will work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation. The framework for this arrangement has been agreed and will be phased in from 1 April 2014.

This re-structure left a gap at Director-level in terms of service improvement, innovation and health intelligence and the Trust undertook a national recruitment exercise, which resulted in no appointment being made; however, with the support of the Remuneration and Terms of Service Committee, I re-evaluated the position and an interim appointment has been made to cover the role with the secondment from NHS England to the role of Director of Service Improvement and Health Intelligence for a six month period on a part-time basis.

In consultation with the Chair, I have adopted a prudent approach to Director-level appointments over the past year; however, the Trust is entering a difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. Therefore, in the coming year the Trust Board structure will be reviewed to ensure it has the capacity,

skills and experience in place within the parameters of its Constitution to support sustainability and ongoing fitness for purpose.

Trust Board is ably supported by an involved and challenging Members' Council, which is a key part of the Trust's governance arrangements. Since becoming a foundation trust in 2009, the Members' Council has gone from strength-to-strength in its ability to challenge and hold non-executive directors to account for the performance of Trust Board. The agendas for Members' Council meetings focus on its statutory duties, areas of risk for the Trust and on the Trust's future direction. Starting in 2013, the Trust has developed through the Members' Council Co-ordination Group a programme of training and development to ensure governors have the skills and experience required to fulfil their duties.

The Trust has continued its ambitious transformational service change programme and associated structures to transform the way it delivers services during 2013/14, ensuring it continues to deliver services that meet local need, offer best care and better outcomes, and provide value for money whilst ensuring that the Trust remains sustainable and viable. Implementation of this programme as well as maintaining delivery of high quality and safe services has presented the Trust with its biggest challenge in 2013/14. Four workstreams are in place to cover mental health services, learning disability services, general community services and forensic services. Each has a Director sponsor and clinical lead and is supported by robust project management arrangements through the newly-established Project Management Office. Although the scale and pace has made it hard to effect and enact fundamental change during 2013/14, the work to build the framework will hold the Trust in good stead for achieving transformational change during the coming year at a faster pace.

During 2013/14, I continued to embed the organisational development model (based on "What really works: the 4+2 formula for sustained business success" (Nohria, Joyce and Robertson)) to support operational delivery. The model provides a framework for principal objectives to be agreed and set by the Board underpinning the Board assurance framework and implementation objectives determined in line with key executive director accountabilities. These objectives are reviewed by me with individual directors on a quarterly basis. Any resulting amendments to the Assurance Framework are reported directly into the Trust Board including any changes to the organisational risk register.

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

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

- financial management;
- information and performance management;
- people management;
- estates management;
- compliance, governance and public involvement; and
- service improvement and development.

This process has been overseen and co-ordinated by me as Chief Executive and led by the Deputy Chief Executive, reviewing Quality Academy development with a formal link to appraisal, ensuring both support to and quality assurance of systems development. As the

Trust enters a critical point in its development, I have commissioned a review of the Quality Academy to ensure it is fit for purpose to support BDUs in the current challenging climate.

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

Following a review of the Trust's mission and values in 2012/13, which involved extensive consultation and engagement, the Trust's new mission and values were launched in April 2013. The Trust has also engaged and consulted service users, carers, staff and stakeholders on its plans for transformation. Clear themes have emerged from the consultation and these themes have underpinned the development of a vision for each transformation programme workstream.

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

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

As Chief Executive, I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust recognises that in the medium- and longer-tem, services across the local health economy are unsustainable in their current form. Therefore, the Trust has to work in partnership with other organisations to ensure that services are provided in the most effective way and that the Trust remains sustainable and viable. One key example of this is the strategic outline case developed with partners in Calderdale and Greater Huddersfield.

The Trust is fully involved in sound and robust partnership arrangements with the four local authorities in Barnsley, Calderdale, Kirklees and Wakefield and the five clinical commissioning groups covering Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield. Relationships have been fostered, developed and built on with commissioners. The Trust also has good working relationships with Local Area Teams at Director and senior management level. The relationship with the Secure Commissioning Group, covering the Trust's medium and low secure services, has proved challenging during 2013/14 as national policy affects commissioning intentions locally. This has impacted on the Trust's forensic services and maintenance of sound relationships locally is a critical factor in supporting the future success of these services.

The Trust has also been closely involved in development of a strategic outline case in Calderdale and Greater Huddersfield with acute and community partners, proposing better integration of all aspects of health and social care and an increased focus on self-care. Closer links have also been made in mid-Yorkshire and Barnsley in relation to the Better Care Fund and, in Barnsley, the Pioneer Initiative.

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

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

The risk and control framework

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS foundation trust condition 4, which applies to foundation trusts only. An internal audit undertaken has provided an opinion of substantial assurance on the arrangements the Trust has in place for ensuring compliance with its Licence conditions, which supports assurance of the validity of the Corporate Governance Statement and is backed by a self-assessment at Board level of the arrangements the Trust has in place. This is supported by my Annual Governance Statement, risk management arrangements, and the Trust's annual plan.

Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary. As Chief Executive, I remain accountable, but delegate executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, while ensuring there is a high standard of public accountability, probity and performance management. Central to this process of quality assurance has been the development of the Quality Academy. The personal objectives of each director have clear risk and assurance statements attached to them. The Assurance Framework reflects the strategic objectives assigned to the Executive Directors.

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

Strategic risk is managed in line with the Trust's Risk Management Strategy, which was amended and approved by the Trust Board in December 2013 to ensure it remains fit for purpose. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in accordance with the principle to reduce risk to as low as reasonably practical. The Trust's risk matrix sets out those risks which, under this principle, are tolerable from those which are unacceptable.

The Trust has a Risk Register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team (EMT) and quarterly by Trust Board, providing leadership to the risk management process. Risk Registers are also developed at service delivery level within BDUs and within support directorates, again being subject to regular

reviews in line with Trust's Risk Management Strategy and monitored monthly by EMT. This includes the opportunity to share concerns and good practice.

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

1. Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency, leading to reputational and financial risk in negotiation of contracts with commissioners mitigated by robust project management arrangements, engagement plan with commissioners and implementation plan reflected in contract monitoring agreed and in place supported by Data Quality Steering Group chaired by Director of Nursing and BDU data quality improvement plans.

2. The Care Packages and Pathways project will not deliver an improvement in service quality and outcomes through the roll out of clustering and mental health currency, mitigated by established project management arrangements and formal working groups linked to commissioners in all areas, work on currency and benchmarking included in the mental health strand of the transformation programme to evidence benefits, and input and participation in Care Packages and Pathways programme to share best practice and benchmark progress.

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

4. Risk that the expectations of Clinical Commissioning Groups (CCGs) for mental health and community services will create a potential reputational risk for the Trust, mitigated by contract terms agreed with commissioners, building relationships through contract and quality Board meetings, development of team-to-team meetings to strengthen partnership working, and development of a marketing strategy to ensure good communications and understanding of the service offer.

5. Risk that the planning and implementation of transformational change through the 'big ticket' programmes will increase clinical and reputational risk through an imbalance of staff skills and capacity between the 'day job' and the 'change job', mitigated by additional resources and external consultancy recruited to support the transformation programme, and key deliverables reviewed and monitored by EMT.

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

7. Changes to national funding arrangements will increase the risk that in 2014/15 contracting round the monies prioritised by commissioners for Trust services will increase the level of savings required to maintain financial viability, mitigated by engagement of expertise to ensure capacity in place and robust EMT review of commissioner intentions and contract management.

8. Commissioning intentions of Barnsley CCG may lead to loss of contract for intermediate care and memory services representing a risk to the Trust's reputation, provision of a full pathway to service users and income/contribution mitigated by agreement with commissioners to roll-over contract at end of March 2014 and continued work with commissioners on a revised service specification, supported by work as part of the transformation of general community services where intermediate care will be more closely aligned to district nurses and community matrons to ensure integration in service pathways.

9. The Trust continues to closely monitor bed management pressures across the Trust and, although no regulatory action was taken following a whistleblowing incident to the Care Quality Commission, mitigating action is in place through robust monitoring against the Bed Management Protocol across all BDUs with clear escalation process and clinical leadership.

10. Specialist commissioning arrangements have significantly altered since the business plan to expand the medium secure women's service was approved. There is a risk that the expanded bed base will be ready for commissioning without either an agreed commissioning model or financial envelope which could potentially have a significant negative revenue impact within the Forensic contract value, mitigated by development of an internal service offer, internal financial modelling and ongoing negotiations with commissioners and the head of specialist commissioning.

In its annual plan to Monitor in March 2014, the Trust also identified a number of risks as a result of regular market analysis and assessment. Mitigating action is in place to address or lessen the impact of these risks.

- The Health and Social Care Act 2012 and the subsequent significant commissioner reforms, including the development of the 'Any Qualified Provider' arrangements. (See 5. above.)
- The current economic climate and the financial challenges this brings. (See 3. and 6. above.)
- The increase in regulation in the NHS, particularly the developing role of the Care Quality Commission. (To be reviewed following the publication of the Francis Report.)
- The potential impact of Payment by Results for mental health services. (See 2. above.)
- Acute care providers in the local environment who are having difficulties within the current financial environment. (Included in 6. above.)
- The position with PCT estate. (Resolved during 2012/13 with the transfer of estate on 1 April 2013.)
- The impact of both demographics and the recession, which will lead to increased demand. (See 3., 5. and 6. above.)
- The increased availability of telehealth and telecare solutions. (Included in 6. above.)

In terms of future risk, the risks outlined above and those in the organisational risk register will continue into 2014/15 and the mitigating action will remain in place.

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

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

The Clinical Governance and Clinical Safety Committee monitors the implementation of recommendations arising from external agencies, such as the Francis Report and Winterbourne View, independent inquiries and external reviews until actions have been completed and closed. A sub-group of the Committee was established in 2010 to provide an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance to the Committee on the performance management of the serious incident review process, associated learning, and subsequent impact within the organisation.

The provision of mental health services carries a significant inherent risk, resulting, on occasion, in serious incidents, which require robust and well governed organisational controls. During 2013/14 there were 45 SIs across the Trust compared to 45 SIs in 2012/13. The increase in reported SIs reflects the changes to reporting arrangements, which, from 1 April 2013, included reporting of pressure ulcer and information governance incidents. The underlying trend for SIs, however, is stable. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

There are four SIs subject to Serious Case Review, one in Kirklees relating to an adult death, one in Kirklees and one in Barnsley relating to domestic homicide, and one in Durham relating to a service user assessed in Calderdale.

Information governance is a key compliance area for the Trust. Control measures are in place to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust SIRO (senior information risk owner). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2014 and messages on compliance with Trust policy have been backed up by regular items in the weekly staff news. Incidents and risks are reviewed by the Information Governance Trust Action Group chaired by the Director lead for information governance, which informs policy changes and reminders to staff.

From June, the Trust was required to report any information governance incidents scoring level 2 or above externally to the Health and Social Care Information Centre (HSCIC) and the Information Commissioners Office (ICO). This has meant that incidents which previously would not have been reported are now reported externally. Three incidents have been reported as meeting the threshold for external reporting under the new reporting requirements. Two of these, which occurred in Wakefield CAMHS, are being followed up by the ICO and could result in enforcement action or a fine. Another incident where a letter with sensitive information was wrongly addressed may also be a level 2 score. There were two level 1 incidents. Under the previous reporting criteria for the period January to July there

were three level 1 incidents and one level 2 incident. The Trust was not required to report these externally

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups, public involvement in the activities of our Trust, membership of the Trust and its Members' Council, and regular dialogue with MPs and other partners. The engagement events held by the Trust during 2013/14 to support its transformation programme have also provided an opportunity to involve service users, carers and stakeholders in the management of risk.

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

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

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

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and a regular programme of unannounced visits. The focus of unannounced visits in 2013/14 has been on areas of risk and to follow up findings of previous visits.

The Trust has assessed itself against the NHS Constitution and a report was presented to Trust Board in June 2013. This covered all areas of the Trust. The Trust meets all the rights and pledges with the exception of the pledge "The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in the relevant discussions". It meets this partly as the Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions when the nature of an individual's illness makes this inappropriate.

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

- The Trust's approach to quality reinforces the commitment to quality care that is safe, person-centred, efficient and effective. The strategy specifies the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board, co-ordinated under the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.

- There are quarterly quality reports for Trust Board and Executive Management Team as well as monthly compliance reporting against quality indicators within performance reports. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes a quarterly self-assessment.
- External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of ECT, PICU and Memory Services; CQC Mental Health Act Visits, NHSLARMS status, national surveys (staff and service user), implementation of Essence of Care and Productive Ward, etc.)
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as SIs, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.

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

- Systematising the collection of service user and care feedback through kiosks and hand held tablets, with a consistent approach to action planning and communication of the response to feedback, including assessment against the Department of Health's Friends and Family Test.
- Development of 'What Matters' linked to the Trust's seven quality priorities
- Review and implementation of a pilot exercise for the '15 Steps Challenge' in Barnsley during 2013 involving service users and carers, and stakeholders, including staff.
- Production of 'How was it for you today' working with service users and staff toolkit to receive service user carer feedback of their experience in out-patient clinics.

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

The Trust was also awarded Customer Service Excellence for all areas during 2013.

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

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Performance EMT, BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. In 2013/14, work has continued to develop and prepare BDUs and support services for the introduction of service line reporting. Work has also continued both internally and with partners on the quality, innovation, productivity and prevention (QIPP) agenda.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities. These annual plans detail the workforce and financial

resources required to deliver the service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings. A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee.

Quality Impact Assessments take an objective view of cost improvements developed by BDUs of the impact on the quality of services in relation to the Trust's seven quality priorities (access, listening to and involving service users, care and care planning, recording and evaluating care, working in partnership, ensuring staff are fit and well to care, and safeguarding). The Assessments are led by the Director of Nursing and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians.

During 2013, the Audit Committee reviewed the Trust's external audit arrangements, and, as the original appointment of Deloitte allowed for an extension of its contract with the Trust for a further period, the Trust sought approval from the Members' Council to re-appoint Deloitte for a further two years. This represented prudent use of Trust funds as it precluded the need for a tender exercise and also resulted in a reduction in the audit fee to reflect that there was no necessity for Deloitte to incur costs on re-tendering activity.

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

In 2013, KPMG, the Trust's internal auditor, began a series of value for money assessments of 'back office' functions, starting with facilities. The outcome of these reviews will be used to improve the support corporate functions provide to BDUs and to achieve efficiencies and improve effectiveness for support functions.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

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

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

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

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

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

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

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

Review of effectiveness

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

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

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

The Trust has developed a values-based appraisal system for staff, which was introduced across the Trust from 1 April 2013. The Trust set a target of 80% of staff having an appraisal in the first quarter of 2013. This presented a significant challenge to the Trust in terms of ensuring staff and managers were trained in the new process and appraisals undertaken. The target was achieved in July 2013.

My review is also informed by reports from external inspecting bodies including external audit and PLACE audits. The Trust scores for each of its in-patient facilities were above the national average except for privacy and dignity in Enfield Down, The Poplars and Castle Lodge. These are community units where, as a result of their size, there were issues in relation to identifying male and female designated lounges, family visiting areas and multi-faith rooms.

In addition, the effectiveness of internal control and risk management systems was subject to external scrutiny and validation through the concluding part of the Monitor assessment process for the transfer of estate from NHS Barnsley, which included external scrutiny by the independent accounting firm KPMG and Hempsons solicitors.

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

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

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

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team. It is based on audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team for internal audit focus on risk and improvement areas. Internal audit provides the findings of its work to management, and

action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

From April 2013 to January 2014, 19 internal audit reports were presented to the Audit Committee. Substantial assurance was received for eight reports and moderate assurance given in seven areas. Three reports were given limited assurance in relation to adult safeguarding, data quality and service level agreements management (non-healthcare). A limited progress opinion was given to a follow up report on the stewardship of financial affairs of patients. Three advisory reports were presented in relation to the Trust's commercial strategy, clinical leadership and self-directed support. KPMG also undertook an investigation on behalf of the Trust.

One audit commissioned by the Director of Corporate Development in relation to procurement (non-pay purchasing) received no assurance. The report was presented to the Committee in October 2013 and the Committee sought robust assurance from the Director of Finance on the Trust's response to the recommendations. In January 2014, KPMG was satisfied and the Committee assured that the Trust had addressed the recommendations with one exception where further work is required, which was accepted by KPMG and the Committee. As a result and taking into consideration the preliminary findings of a financial management audit, which also looked at the progress towards completion of the recommendation arising out of the procurement audit, KPMG confirmed that it was sufficiently assured of the actions the Trust had taken that the outcome of the audit would not affect its Head of Internal Audit Opinion.

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

Seven reviews are ongoing at the end of the year and are due to report to the Audit Committee in April 2014.

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

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

Conclusion

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

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

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

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Steven Michael
Chief Executive
23 May 2014

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 8.3

Title:	**Monitor Code of Governance**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is to provide assurance to Trust Board that the Trust meets the revised Code of Governance issued by Monitor for compliance from 1 January 2014.
Vision/goals:	The Code of Governance provides a framework to ensure the Trust has a strong and effective Board, which enables it to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers/ previously considered by:	Trust Board received assurance in relation to compliance with the Code of Governance in April 2013.
Executive summary:	The Code of Governance is intended to assist Boards of NHS Foundation Trusts to improve governance practices by bringing together the best practice of public and private sector corporate governance. The Trust has routinely assessed itself against the requirements of the Code and has reported the outcome of this assessment to Trust Board. Monitor issued a revised Code on 1 January 2014 and the outcome of the latest review is included as an annex to this paper. The assessment demonstrates that the Trust complies with the Code although there are some areas for development, which will be addressed during 2014. Although the Code of Governance is not mandatory, Monitor has adopted an approach of 'comply or explain' and Trusts are required to comment on compliance with the Code in their annual reports, including identifying any areas where they do not comply.
Recommendation:	**Trust Board is asked to receive the attached self-assessment and confirm it provides assurance that processes are in place to ensure the Trust complies with the Monitor Code of Governance.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

NHS Foundation Trust Code of Governance – action plan March 2014
(Assessment against the revised Code 1 January 2014)

Items marked in light blue are for inclusion in annual report

Code provision	Current position	Action	Lead	When	Where
SECTION A LEADERSHIP					
A.1 The role of the Board of Directors **Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation Trust.** **The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits of the trust as a whole and for the public.**					
A.1.1a The board of directors should meet sufficiently regularly to discharge its duties effectively.	Trust Board meets monthly (except for August) on a three-monthly cycle (business and risk, strategic and public).	None	Chair		Trust Board agenda plan
A.1.1b There should be a formal schedule of matters specifically reserved for decision by the board of directors.	Trust has in place Reservation of Powers to the Board and Scheme of Delegation, which is regularly reviewed by Trust Board. An annual schedule of Trust Board business is in place and agreed with the Chair.	Scheme of Delegation to be reviewed following review of Quality Academy (September 2014) and linked to service line reporting.	SM/AF/ DS		Scheme of Delegation Trust Board plan
A.1.1c Above should include a clear statement detailing the roles and responsibilities of the council of governors.	Set out in the Trust's Constitution, the Members' Council Standing Orders and Members' Council Code of Conduct.	Given the change to the Members' Council role as a result of the Health and Social Care Act 2012, a formal statement will be developed to provide absolute clarity on the roles and responsibilities.	DS	Summer 2014	Trust Constitution/ Trust Board governance handbook
A.1.1d The above statement should also describe how any disagreements between the council of governors and board of directors will be resolved.	Contained in Constitution (Trust Board Standing Orders).	To be made explicit in the statement of responsibilities.	DS	Summer 2014	Trust Constitution/ Trust Board governance handbook
A.1.1e Summary statement of how the board of directors and council of governors operate, including a summary of the types of decisions to be taken by each and which are delegated to the executive management by the board of directors. These arrangements should be	Included in annual report. Ongoing review through the year through agenda setting.	None	DS		Annual report

Code provision	Current position	Action	Lead	When	Where
reviewed at least annually.					
A.1.2a The annual report should identify the chair, deputy chair, the chief executive, the senior independent director and the chair and members of the nomination, audit and remuneration committees.	Included in annual report	None	DS		Annual report
A.1.2b The annual report should also set out the number of meetings of the board of directors and the above committees and individual attendance by directors.	Formal record of attendance is maintained for Trust Board and its Committees and is included in the annual report.	None	DS		Formal record
A.1.3 The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for decision-making and forward planning.	The Trust's mission, vision, values and goals are available on the Trust's website and can be provided on request. The Trust's statement of its objectives is set out in its business plan and its quality priorities are included in the Quality Accounts. A forward look is contained in the Trust's annual report. All documents are available on the Trust's website. Monitor publishes a copy of all Foundation Trust annual plans on its website and a summary of the plan is publicly available following submission to Monitor.	None	DS		Website/ annual report
A.1.4a The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory requirements and approved plans and objectives.	Trust Board receives performance and financial information on a monthly basis and detailed human resources, compliance, quality and patient experience reports quarterly. Trust Board also receives assurance through Quality and financial accounts. Trust Board Committees provide assurance to Trust Board on matters delegated to them by Trust Board, including CQC registration, NHS LARMS and Monitor's compliance framework.	None	AF/DS/ TB		Performance reports
A.1.5 The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate, and in particular in high	Performance reports to Trust Board contain relevant performance indicators to enable Trust Board to assess progress and delivery of performance. These are reviewed annually for relevance, timeliness and risk. This includes externally	None	AF/DS/ TB		Performance reports

Code provision	Current position	Action	Lead	When	Where
risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	determined indicators, such as Monitor targets and CQUINs set by commissioners. Trust Board also receives a quarterly report on patient experience. Independent advice/assistance is sought, in particular from KPMG and Deloitte, on a range of issues, as appropriate.				
A.1.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the Department of Health, NHS England, the Care Quality Commission and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occur.	The Trust's approach to quality is set out in the Quality Improvement Strategy approved by Trust Board in September 2013. The Trust's Quality Accounts contain a range of indicators of quality, which are set following wide consultation with stakeholders and the Trust's Members' Council. Trust Board receives a biannual update on compliance with Monitor's Quality Governance Framework and quarterly update on CQC registration.	None	TB		Quality Improvement Strategy/ Quality Accounts/ Annual report
A.1.7 The chief executive, as the accounting officer, should follow the procedure set out by Monitor for advising the board of directors and council of governors, and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	Chief Executive would do so as and when appropriate.	None	SM		Trust Board minutes
A.1.8 The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	Vision, values and goals set by Trust Board and reviewed at least annually. Trust Board signed up to the Combined Code and Nolan Principles in March 2006. The duties and obligations of Directors are set out in Trust Board Standing Orders and in the Members' Council Standing Orders for Governors. Both Trust Board and the Members' Council are reminded of the obligations during the annual declaration of interests exercise. As NHS employees, all staff are required to	None	DS		MVVG Constitution and Standing Orders Register of interests Policy

Code provision	Current position	Action	Lead	When	Where
	adhere to NHS values and code of conduct and the Trust has a Standards of Business Conduct in Public Service Policy in place. A risk assessment of the Trust's arrangements in response to the Bribery Act was undertaken by internal audit and presented to the Audit Committee in October 2013. A recommendation was made regarding the Trust's practice in relation to assessing risk as a result of staff declarations and a paper was presented to the Audit Committee in January 2014. Trust Board and the Members' Council received a presentation from the local counter fraud specialist in relation to Directors' and governors' responsibilities in relation to counter fraud and bribery.				
A.1.9 The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interests are dealt with.	The Trust's values ensure that Trust Board operates openly and transparently, with high standards of probity and responsibility. Trust Board has criteria for matters submitted to its private session (commercial-in-confidence, matters of patient confidentiality or if a matter would identify a member of Trust staff or the public). The Trust's Constitution, Standing Orders and Declaration of Interests Policy set out how conflicts of interest are dealt with.	None	DS		Values Constitution, etc.
A.1.10 The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Trust Board agreed in March 2008 to take out Directors' indemnity insurance on Authorisation and this is renewed annually.	None	DS		Insurance policy
A.1.11 Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council	The above insurance also covers governors on the Members' Council who act in good faith and in accordance with their duties.				

Code provision	Current position	Action	Lead	When	Where
of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.					
A.2 Division of responsibilities **There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the board of directors and council of governors and the executive responsibility for the running of the NHS foundation trust's business. No one individual should have unfettered powers of decision.**					
A.2.1 The division of responsibilities between the chair and chief executive should be clearly established, set out in writing and agreed by the board.	Responsibilities of Chair and Chief Executive are set out in the Standing Orders, approved by Trust Board in March 2008. These were reviewed early in 2011 as a result of the transfer of provider services under Transforming Community Services.	This will be expanded further following guidance in the Foundation Trust Network's "The foundations of good governance" and included in the Trust Board governance handbook.	DS	Summer 2014	Standing Orders/ Trust Board governance handbook
A.2.2 The roles of chair and chief executive must not be undertaken by the same individual.	The Trust and its Board would not allow this to happen.	None	Chair		N/A
A.3 The chair **The chair is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.**					
A.3.1 The chair should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chair of the same NHS foundation trust.	The Members' Council, through the Nominations Committee, is responsible for appointing the Chair of the Trust. Independence criteria would be included in any consideration for appointment to the role of Chair of the Trust. The Trust's Constitution states that the Chair should meet the independence criteria.	None	DS		Nominations Committee
A.4 Non-Executive Directors **As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.**					
A.4.1a In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chair and to serve as an intermediary for the other directors where necessary. The senior independent director could be the deputy chairman.	The Nominations Committee is responsible for ensuring there is a robust and transparent process for appointing the Senior Independent Director, which is ratified by the Members' Council. The Trust follows best practice in appointing the Deputy Chair as the Senior Independent Director.	None	Chair/DS		Nominations Committee and Members' Council minutes
A.4.1b The senior independent director should be available to governors if they have	SID attends all Members' Council meetings and contact can be made through the	None	DS		

Code provision	Current position	Action	Lead	When	Where
concerns that contact through the normal channels of chair, chief executive, finance director or trust secretary has failed to resolve or for which such contact is inappropriate.	Board Secretary or Chair's office.				
A.4.2a The chair should hold meetings with the non-executive directors without the executives present.	The Chair meets with Non-Executive Directors on a quarterly basis.	None	Chair		Chair's office
A.4.2b Led by the senior independent director, the non-executive directors should meet without the chair, at least annually, to evaluate the chair's performance, and on such other occasions as are deemed appropriate.	A formal process in place to evaluate the Chair's performance led by the Deputy Chair/Senior Independent Director, which includes a meeting of the Non-Executive Directors without the Chair.	None	Deputy Chair/SID		Members' Council papers
A.4.3a Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Concerns and issues raised by Directors during Trust Board meetings are recorded in the minutes. If concerns were raised that could not be resolved, the matter would be recorded in the minutes supported by any action agreed to address the situation.	None	Chair/ Board Secretary		Trust Board minutes
A.4.3b On resignation, a director should provide a written statement to the chair for circulation to the board if they have such concerns.	The Chair would ask for such a statement if the situation arose.	None	Chair		Chair's office
A.5 Governors **The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.** **The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.** **Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed the. The trust should ensure governors have appropriate support to help them discharge this duty.**					
A.5.1a The council of governors should meet sufficiently regularly to discharge its duties. Typically, the council of governors would be expected to meet as a full council at least four times per year.	The Members' Council meets quarterly.	None	Chair		Members' Council meeting minutes
A.5.1b Governors should, where practicable, make every effort to attend the meetings of the council of governors where practicable. The NHS foundation trust should take appropriate steps facilitate attendance.	Code of Conduct for Governors sets out attendance requirements for Governors. The minimum commitment has been discussed by the Members' Council and agreement reached on the principles. The	None	DS		Members' Council meeting minutes/ record of

Code provision	Current position	Action	Lead	When	Where
	Trust gives timely notice of meetings, ensures papers are understandable and simple, offers assistance to get to, and support at, meetings. The Trust also offers any governor the opportunity to seek clarification or further information in advance of the meeting on any of the issues or papers on the agendas. The Chair of the Trust is available prior to Members' Council meetings for governors. The agendas are planned to ensure that as many governors as possible are able to participate and meetings contain items that are taken formally, through presentations, through question and answer sessions, and more informal group discussions.				attendance
A.5.2a The council of governors should not be so large as to be unwieldy. The council of governors should be off sufficient size for the requirements of its duties.	As a result of the Health and Social Care Act 2012, the structure of the Members' Council was reviewed and membership decreased from 42 to 33 governors. This: ➢ allows the Members' Council to discharge its duties; ➢ is sufficient size not to be too unwieldy; and ➢ ensures representation of the communities the Trust serves and stakeholder interests. In October 2013, an additional seat was instated to represent the 'rest of South and West Yorkshire'.	None	DS		Constitution
A.5.2b The roles, structure, composition and procedures of the board of governors should be reviewed regularly as described in B.6.5.	There is an annual session to evaluate the contribution and work of the Members' Council. This is facilitated by an external facilitator and includes a self-assessment by governors, both individually and collectively, of their contribution and effectiveness.	Further work will be done with the Chair of the Trust and the Members' Council to ensure there is a structured approach to induction, training and development for the Members' Council both individually and collectively, particularly to reflect the enhanced role in the Health and Social Care Act 2012.	Chair/DS	Summer 2014	Notes from the session/ evaluation outcome
A.5.3a The annual report should identify the members of the council of governors,	Included in the annual report.	None	DS		Annual report

Code provision	Current position	Action	Lead	When	Where
including a description of the constituency or organisation they represent, whether they were elected or appointed, and the duration of their appointments.					
A.5.3b The annual report should also identify the nominated lead governor.	Included in the annual report	None	DS		Annual report
A.5.3c A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	Formal record of attendance is maintained for the Members' Council (and included in the annual report).	None	DS		Formal record
A.5.4 The roles and responsibilities of the council of governors should be set out in a written document. The statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The roles and responsibilities of the Members' Council are set out in Members' Council Standing Orders.	A formal statement will be developed following guidance in the Foundation Trust Network's "The foundations of good governance" and will be included in the Trust Board governance handbook.	DS	Summer 2014	Constitution/ Trust Board governance handbook
A.5.5 The chair is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take a lead in inviting the chief executive to their meetings and inviting attendance by other executive and non-executive directors as appropriate. In these meetings other governors may raise questions of the chair or his/her deputy or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	The Chief Executive, other Non-Executive and Executive Directors are invited to each Members' Council meeting.	None	DS		Minutes record attendance
A.5.6a The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the general wellbeing of the NHS foundation trust.	There is currently no written policy in place. The Trust is required to appoint a Senior Independent Director on the Trust Board and this is done through the Nominations Committee (see A3.3a above).	As a result of the Health and Social Care Act 2012, a formal statement will be developed in relation to the Members' Council engagement with Trust Board given the changes to the role of governors. The policy will require the approval of Trust Board and the Members' Council and will be included in the Trust Board governance handbook.	Chair/DS	Summer 2014	Written statement/ Trust Board governance handbook
A.5.6b The council of governors should input into the board's appointment of a senior	The process to appoint the Senior Independent Director is overseen by the	None	Chair		Nominations Committee

Code provision	Current position	Action	Lead	When	Where
independent director (see A.4.1).	Nominations Committee. The Trust follows best practice in appointing the Deputy Chair in this role.				minutes
A.5.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and use, where possible, using clear, unambiguous language.	Joint meeting with Trust Board on an annual basis. Members of Trust Board attend Members' Council meetings and governors are encouraged to attend public meetings of Trust Board. Agendas and minutes are provided to governors in a timely way and public papers are available on the Trust's website. The Members' Council Co-ordination Group sets the agenda for Members' Council meetings with the Chair. Papers are prepared, where possible, using clear, unambiguous language with jargon kept to a minimum.	None	DS		Members' Council papers
A.5.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all other means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.	Monitor provides guidance on this in "Your Statutory Duties: A reference guide for NHS foundation trust governors", which has been given to all Governors. The Lead Governor and the Nominations Committee ensure that there are formal mechanisms in place to address any such situation. The Senior Independent Director attends Members' Council meetings to build relationships with governors and to engender trust and confidence.	None	DS		Standing Orders
A.5.9 The council of governors should receive and consider appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	The Members' Council receives high level performance and operational information based on that submitted to Trust Board, to enable it to discharge its duties. This is regularly reviewed with the Members' Council. Additional information requested is provided within agreed timescales.	None	DS		Members' Council papers
SECTION B EFFECTIVENESS					
B.1 The composition of the Board **The board of directors and its committees should have an appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.**					
B.1.1a The board of directors should identify	All Non-Executive Directors are considered	None	DS		Annual

Code provision	Current position	Action	Lead	When	Where
in the annual report each non-executive director it considers to be independent.	to be independent and a statement to this effect is included in the annual report. Non-Executive Directors are asked to sign a declaration regarding their independence on an annual basis.				report
B.1.1b The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, or could appear to affect, the Director's judgement. The board of director should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.	All Non-Executive Directors are considered to be independent. The declaration of interests process was revised in September 2011 and now asks Non-Executive Directors to specifically declare their independence.	None	DS		Register of interests and annual report
B.1.2 At least half the board of directors, excluding the chair, should comprise non-executive directors determined by the board to be independent.	The Trust's Constitution states that Trust Board should be made up of a non-executive Chair, up to six other non-executive directors, and up to six executive directors, one of which is the Chief Executive, and that there will be at least one more non-executive director than executive directors, including the Chair of the Trust. All Non-Executive Directors are considered to be independent.	None	DS		Constitution and Standing Orders
B.1.3 No individual should hold, at the same time, positions of director and governor of any NHS Foundation Trusts.	The Trust uses the declaration of interests process to ensure this does not happen.	None	DS		
B.1.4a The board of directors should include in its annual report a description of each director's expertise and experience.	Information included in the Trust's annual report. Process in place to update annually.	None	DS		Annual report
B.1.4b Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	Included in annual report.	None	DS		Annual report
B.2 Appointments to the board					

Code provision	Current position	Action	Lead	When	Where
There should be a formal, rigorous and transparent procedure for the appointment of directors. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence. **The search for candidates for the board of directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and requirements of the trust.** **The board of directors and council of governors should also satisfy themselves that plans are in place for orderly succession for appointments to the board so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.**					
B.2.1a The nominations committee(s), with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The Nominations Committee(s) should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise within the board to meet them.	There are two 'nominations' committees in place. The Nominations Committee is responsible for the appointment of the Chair and Non-Executive Directors. The Remuneration and Terms of Service Committee, under delegated authority from Trust Board, is responsible for the appointment of the Chief Executive and for overseeing the appointment of Executive Directors.	None	DS/AGD		ToR Nominations Committee and Remuneration and Terms of Service Committee
B.2.2 Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at Monitor's discretion, an exemption to this may be granted. Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.	The Trust is awaiting guidance from Monitor and the CQC on the fit and proper persons' test and how it should be applied to current and future Directors and governors.	None at present	Chair/DS		
B.2.3a There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair).	See B.2.1a above.	None	DS/AGD		ToR Nominations Committee and Remuneration and Terms of Service Committee
B.2.3b The nominations committee(s) should	Contained in the Committee's terms of	None	Chair/DS		ToR

Code provision	Current position	Action	Lead	When	Where
regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in light of this evaluation, prepare a description of the role and capabilities required for the appointment of both executive and non-executive directions, including the chair.	reference. The Nominations Committee considers the structure, size and composition of Trust Board when agreeing the process to appoint Non-Executive Directors and seeds applications in light of this consideration.				Nominations Committee
B.2.4 The chair or an independent non-executive director should chair the nominations committee(s).	The Chair of the Trust usually chairs the Nominations Committee as set out in the terms of reference. In the absence of the Chair of the Trust or when the Committee is considering matters relating to the appointment of the Chair, the Committee will be chaired by the Lead Governor. If the Lead Governor is unavailable, the Committee can either ask the Deputy Chair/Senior Independent Director to chair the meeting if there is no conflict of interest or agree one of its members to act as Chair for that meeting, again if there is no conflict of interest.	None	Chair/DS		ToR Nominations Committee
B.2.5 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	The Nominations Committee works on behalf of governors overseeing the process for nominating and appointing the Chair and Non-Executive Directors. Papers are presented to the Members' Council outlining the process for recruitment and appointment at regular intervals during the process. Support is sought for any process.	None	Chair		Nominations Committee minutes and papers to Members' Council
B.2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	As a minimum, the Chair of the Trust, the Chief Executive of the Trust and two members of the Members' Council (one elected and one appointed) will form the membership. A Governor to represent the interests of service users/carers and the Lead Governor are also members of the Committee.	None	Chair/DS		ToR Nominations Committee

Code provision	Current position	Action	Lead	When	Where
If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	Not applicable.				
B.2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Chair represents the views of Trust Board in determining the skills and experience required. The Nominations Committee makes a recommendation to the Members' Council for appointment and will explain the rationale for this recommendation.	None	Chair		
B.2.8 The annual report should describe the process followed by the council of governors in relation to the appointments of the chair and non-executive directors.	Included in the annual report.	None	DS		Annual report
B.2.9 An independent external adviser should not be a member of or have a vote on the nominations committee(s).	No external adviser is a member of or has vote on either the Nominations Committee or the Remuneration and Terms of Service Committee.	None	DS/AGD		
B.2.10 A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	Included in the annual report. The terms of reference for both the Nominations Committee and the Remuneration and Terms of Service Committee are available on request.	None	DS		Annual report
B.3 Commitment **All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.**					
B.3.1a For the appointment of a chair, the nomination committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies.	This is done as part of the appointment process.	None	DS		ToR Nominations Committee
B.3.1b A chair's other significant commitments should be disclosed to the council of governors before appointment and included in	This would be done as appropriate. The declarations of interest for all members of Trust Board are included in the annual	None	DS		Annual report

Code provision	Current position	Action	Lead	When	Where
the annual report.	report.				
B.3.1c Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	This would be done as appropriate. The declarations of interest for all members of Trust Board are included in the annual report.	None	DS		Annual report
B.3.1d No individual, simultaneously whilst being a chair of an NHS foundation trust, should be the substantive chair of another NHS foundation trust.	Included in Constitution.	None			Constitution
B.3.2a The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them.	If requested, the Trust would share the terms and conditions of Non-Executive Director appointments. The expected time commitment is set out in the Service Level Agreement for Non-Executive Directors. It is made clear both at interview and in the SLA that the post should only be taken up if the individual can fulfil the time commitment.	None	Chair/DS		NEDs' SLA
B.3.2b Non-executive Directors' other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	Declaration of interest process only undertaken when appointment confirmed. Trust Board register of Interests is publicly available in Trust Board papers and on the Trust's website. During the appointment process, the Nominations Committee, through the interview panel, would be responsible for ensuring any significant commitments were identified and any implications for the Trust raised with the candidate.	None	DS		Declaration of interests register/ minutes of Members' Council
B.3.3 The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairship of such an organisation.	Trust Board will be alerted to guidance if such a situation arises.	None	Chair		
B.4 Development **All directors and governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and governors should make every effort to participate in training that is offered.** **The chair should ensure that directors and governors continually update their skills, knowledge and familiarity with the NHS foundation trust and its obligations to fulfil their role on the board, the council of governors and on committees. The NHS foundation trust should provide the necessary resources for developing and**					

Code provision	Current position	Action	Lead	When	Where
updating its directors' and governors' skills, knowledge and capabilities. **To function effectively, all directors need appropriate knowledge of the NHS foundation trust and access to its operations and staff.**					
B.4.1 The Chair should ensure that new directors and governors receive a full and tailored induction on joining the board or council of governors. As part of this, directors should seek out opportunities to engage stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	Each Non-Executive Director has an induction programme tailored to individual needs, experience and interests, with a core programme that includes meetings with the Chief Executive, Executive Directors, Non-Executive Director colleagues, visits to services and the Monitor Non-Executive Director induction programme.	None	Chair		Chair's office
	Each Executive Director has an induction programme tailored to individual needs, experience and interests, with a core programme that includes meetings with the Chair, Non-Executive Directors, Executive Director colleagues, relevant staff and visits to services.	None	Chief Executive		Chief Executive's office
	The Trust offers 1:1 support and 'buddying' as part of the induction programme for Governors. New members also participate in the annual evaluation of Members' Council activity, which enables existing members to assess their performance over the year and for new Governors to learn from the experience of others. Attendance at national GovernWell training modules is also encouraged.	Following changes to the role and responsibilities of governors as a result of the Health and Social Care Act 2012, the support offered to governors both on appointment and during their term(s) of office has been reviewed. A formal induction programme, a structured training and development programme and access to the national governor training and development programme run by the Foundation Trust Network will be developed to ensure that governors have the skills and experience they and the Trust need to meet the new responsibilities.	DS	Summer 2014	
B.4.2 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Responsibility for the training and development of Non-Executive Directors rests with the Chair of the Trust. The Chair undertakes six-monthly review meetings with Non-Executive Directors and ensures that any training and development needs are identified and how these are	None	Chair		Nominations Committee minutes

Code provision	Current position	Action	Lead	When	Where
	addressed agreed. The outcome of these review meetings is shared with the Nominations Committee annually. Responsibility for the training and development of Executive and other Board-level Directors rests with the Chief Executive. The Chief Executive undertakes quarterly review meetings with Directors and ensures that any training and development needs are identified and how these are addressed agreed. The outcome of these review meetings is shared with the Remuneration and Terms of Service Committee annually.	None	Chief Executive		Remuneration and Terms of Service Committee minutes
B.5 Information and support **The Board of directors and council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in "Your statutory duties: A reference guide for NHS foundation trust governors".**					
B.5.1 The board of directors and the council of governors should be provided with high quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and council of governors should agree their respective information needs with the executive directors through the chair. The information for the both should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	The Trust has an ongoing process of review of its Trust Board and performance reporting arrangements. All members of Trust Board are involved in this process to ensure information remains fit for purpose for Trust Board. Directors have access to information they require about the Trust to enable them to discharge their duties. As set out in B.1.5, the Members' Council receives high level performance and operational information based on that submitted to Trust Board, to enable it to discharge its duties. This has been reviewed and agreed by the Members' Council Co-ordination Group as appropriate. Papers to the Members' Council contain sufficient information to enable individuals to come to a view on the items put forward and further information is available should it be required.	None	DS		Trust Board and Members' Council papers and minutes
B.5.2 The board of directors, and in particular non-executive directors, may reasonably wish to challenge assurances received from executive management. They need not seek	Both Non-Executive and Executive Directors challenge assurances given at Trust Board and seek clarification and further information to inform decisions and	None	Chair		Trust Board minutes

Code provision	Current position	Action	Lead	When	Where
to appoint a relevant adviser for each and every subject area that comes before the board of directors although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasions, non-executives may reasonably decide that external assurance is appropriate.	discussion. Access to external assurance is available.				
B.5.3a The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	As appropriate, this is in place through the Chair and Chief Executive.	None	Chair/CE		
B.5.3b Decisions to appoint an external advisor should be the collective decision of the majority of non-executive directors.	As appropriate, this would be facilitated through the Chair.	None	Chair/CE/ DS		
B.5.3c The availability of external sources of advice should be made clear at the time of appointment.	The Non-Executive Director appointment letter includes reference to independent sources of information.	None	DS		Appointment letter
B.5.4a Committees should be provided with sufficient resources to undertake their duties.	Administrative arrangements are in place to support committees. Any further need for resources would be considered as appropriate.	None	Chair/DS		
B.5.4b The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties, with such arrangements agreed in advance.	Administrative arrangements are in place to support the Members' Council. Any further need for resources would be considered as appropriate.	None	Chair/DS		
B.5.5 Non-Executive Directors should consider whether they are receiving the necessary information and feel able to raise appropriate challenge of recommendations or decisions of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other	Information is provided to Non-Executive Directors to ensure they are able to provide challenge and inform decision-making. Where further information is required, this is provided.	This will be kept under review to ensure all members of Trust Board are sufficiently equipped to provide challenge and inform decision-making.	Chair/CE		Trust Board papers and minutes

Code provision	Current position	Action	Lead	When	Where
leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.					
B.5.6a Governors should canvass the opinion of the trust's members and the public, and, for appointed governors, the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	This remains an area for development as the Trust matures as a Foundation Trust. The Members' Council is involved in developing the strategic direction of the Trust and these views were communicated to Trust Board and considered in the discussions at Board level. The Trust does not have the resource for governors to speak to 13,000 members. Dialogue and involvement groups are asked to comment on the Trust's plans and processes for consultation and engagement are included in any changes to services and/or estate.	This is an objective for the Members' Council and further work will be undertaken on how governors can canvass the opinion of their members and, for appointed governors, the organisation they represent on the Trust's forward plans, bearing in mind the Trust's resources and capacity. A small working group will be established to look at creative ways governors can communicated with members as part of an ongoing work programme.	DS	Summer 2014	
B.5.6b The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	The annual report will contain a summary of the Trust's current position and its plans.		DS		Annual report
B.5.7 Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans and, if not, the reasons for this.	The Members' Council is involved in developing the strategic direction of the Trust, these views are communicated to Trust Board and considered in the discussions at Board level, and the Members' Council is aware of where their views have been incorporated.	None	Chair/CE		Annual plan/ Members' Council minutes
B.6 Evaluation **The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.** **The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chair should take the lead on the evaluation of the executive directors.** **The council of governors, which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chair and the non-executives, with the chair and the non-executives. The outcomes of the evaluation of the non-executive directors should be agreed with them by the chair. The outcomes of the evaluation of the chair should be agreed by him/her with the senior independent director. The outcomes of the evaluation of the non-executive directors and the chair should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair.** **The council of governors should assess its own collective performance and its impact on the NHS foundation trust.**					
B.6.1 The board of directors should state in	A summary of the Trust Board	None	DS		Annual

Code provision	Current position	Action	Lead	When	Where
the annual report how performance evaluation of the board, its committees and its directors, including the chair, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	development programme and activity through the year will be included in the annual report.				report
B.6.2 Evaluation of the boards of NHS foundation trusts should be externally facilitated every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection with the trust.	The governance reviews proposed by Monitor will provide the framework for evaluation of Trust Board. Final guidance on the reviews is awaited.	Agree Trust action when final guidance published by Monitor.	DS	Not confirmed by Monitor but expected summer 2014	
B.6.3 The senior independent director should lead the performance evaluation of the chair, within a framework agreed by the council of governors and taking into account the views of directors and governors.	A formal annual process in place to evaluate the Chair's performance led by the Deputy Chair/Senior Independent Director, agreed by the Members' Council and involving the views of Directors and governors.	None	SID		Report on outcome to Members' Council
B.6.4 The chair, with the assistance of the board secretary if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	For Non-Executive Directors, training and development are identified by the Chair as part of the appraisal process and on an ongoing basis to ensure personal and Trust needs are met and to ensure Non-Executive Directors can fulfil the requirements of their role. For Executive Directors, training and development are identified by the Chief Executive as part of the appraisal process, Directors' quarterly reviews and on an ongoing basis to ensure personal and Trust needs are met. Any development needs in relation to their duties as a member of Trust Board would also be identified in this way.	None	Chair CE/Chair		Appraisal records
B.6.5 Led by the chair, the council of governors should periodically assess their collective performance and they should	The Members' Council assesses its performance in two ways. ➢ Through individual annual appraisals	None	DS/MC		Annual report/Like Minds/

Code provision	Current position	Action	Lead	When	Where
regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on holding the non-executive directors individually and collectively to account for the performance of the board of directors, communicating with their member constituencies and the public and transmitting their views to the board of directors, and contributing to the development of forward plans of the NHS foundation trust. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.	with the Chair of the Trust. ➢ Through an annual evaluation of the contribution the Members' Council has made, facilitated by an external consultant. The contribution and involvement of Members' Council is included in report to the annual members' meeting, included in regular updates in Like Minds (members' magazine), and in the annual report.				annual self-assessment
B.6.6 There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest, which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions by a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.	Provision for this is included in the Constitution and in the Members' Council Code of Conduct.	None	DS		Constitution
B.7 Re-appointment of directors and re-election of governors **All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals.** **The performance of executive directors of the board should be subject to regular appraisal and review.** **The council governors should ensure planned and progressive refreshing of the non-executive directors.**					
B.7.1a In the case of the re-appointment of non-executive directors, the chair should	The Chair confirms this as appropriate and discusses the performance and	None	Chair		Minutes Nominations

Code provision	Current position	Action	Lead	When	Where
confirm to the governors that, following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.	contribution of a Non-Executive Director with the Nominations Committee when considering any proposal for re-appointment.				Committee/ Members' Council
B.7.1b Any term beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board.	Constitution specifies the term of office for Non-Executive Directors. The Nominations Committee will recommend the term of office to the Members' Council as part of the recommendation to appoint if it is different to the standard term of three years. The Chair can be re-appointed for a further three years (up to a maximum of nine years) subject to the approval of the Members' Council. Non-Executive directors can be re-appointed for a further three years (up to a maximum of nine years), subject to approval by the Members' Council and following confirmation by the Chair that they have performed effectively and remain committed to the role. Appointments beyond six years will be subject to annual review. However, the Chair has made clear his expectation that Non-Executive Directors would ideally serve for two terms only; however, there may be exceptional circumstances where continuity or the skills and experience of a Non-Executive Director require re-appointment for a further term to meet the needs of the Trust.	None	Chair		Constitution
B.7.1c Non-executive directors may in exception circumstances serve longer than six years (e.g. two three-year terms following authorisation of the NHS foundation trust), but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive director's independence.	See above.	None	Chair		Constitution
B.7.2a Elected governors must be subject to	Included in Constitution.	None	DS		Constitution

Code provision	Current position	Action	Lead	When	Where
re-election by the members of their constituency at regular intervals not exceeding three years.					
B.7.2b The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	Model election rules allow candidates to make a statement explaining why they should be elected/re-elected. The Trust provides information on attendance at formal meetings for those elected Governors seeking re-election as required by the model election rules.	None	DS		Election materials
B.8 Resignation of directors **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board of directors and works with the council of governors to ensure there is appropriate succession planning.**					
B.8.1 The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Remuneration and Terms of Service Committee would undertake such a risk assessment on behalf of Trust Board should the need arise. Although not specifically stated in the Committee's terms of reference, this responsibility is implied through the Committee's management of the process to appoint the Chief Executive and Executive Directors.	Chair and lead Director to review the Committee's terms of reference to ensure this is an explicit duty.	Chair of the Committee/AGD		R&TSC papers and minutes
SECTION C ACCOUNTABILITY					
C.1 Financial, quality and operational reporting **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**					
C.1.1a The directors should explain in the annual report their responsibility for preparing the annual report and accounts and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	Statement included in the annual report and accounts.	None	DS/AF		Annual report
C.1.1b There should be a statement by the external auditor about their reporting responsibilities.	Statement included in the annual report and accounts.	None	DS/AF		Annual report
C.1.1c Directors should also explain their	Statement included in the annual report	None	DS/TB		Annual

Code provision	Current position	Action	Lead	When	Where
approach to quality governance in the Annual Governance Statement (within the annual report).	and accounts.				report
C.1.2 The directors should report that the NHS foundation trust is a going concern, with supporting assumptions or qualifications as necessary.	Included in the annual report and accounts.	None	DS/AF		Annual accounts
C.1.3 At least annually and in a timely manner, the board of directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcomes data, to allow members and governors to evaluate its performance.	Included in the annual report and accounts.	None	Chair/SM		Annual report
C.2 Risk management and internal control **The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.** **The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The board should report on internal control through the Annual Governance Statement in the annual report.**					
C.2.1 The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so. A review should cover all material controls, including financial, operational and compliance controls.	Accounting Officer produces an Annual Governance Statement and management report on risk annually. These are reviewed by the Audit Committee and Trust Board, contained in the Trust's annual report and accounts, and reported to the Members' Council. Trust Board also prepares a Corporate Governance Statement, which assesses the effectiveness of the risk management and internal controls to support the Trust's objectives going forward.	None	CE/DS		Annual Governance Statement/ Corporate Governance Statement/ annual accounts
C.2.2 A trust should disclose in the annual report: a) if has an internal audit function, how the function is structure and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for	The Trust will include a disclosure in its annual report on the internal audit function within the Trust, how it is structured and what role it performs. Not applicable.	None	DS		Annual report

Code provision	Current position	Action	Lead	When	Where
evaluating and continually improving the effectiveness of its risk management and internal control processes.					
C.3 Audit committee and auditors **The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.**					
C.3.1a The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors.	An Audit Committee is in place and three Non-Executive Directors are members. (All Non-Executive Directors are considered to be independent.)	None	DS/AF		Audit Committee ToR
C.3.1b The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience.	The Audit Committee is chaired by a Non-Executive Director with recent and relevant financial experience. The two other members have commercial and legal experience. The Committee is considered to have sufficient skills to discharge its responsibilities.	Both internal and external audit have been asked to support the Trust in providing guidance on best practice for Audit Committees to ensure that appropriate skills are in place.	Chair of Audit Committee		
C.3.1c The chair of the trust should not chair or be a member of the audit committee. He/she can, however, attend meetings by invitation as appropriate.	The Chair of the Trust is not a member of the Audit Committee. He attends at least one meeting annually as part of his appraisal process for Non-Executive Directors and the Committee meeting where the annual report and accounts are considered and approved.	None	DS		
C.3.2a The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.	The Audit Committee has terms of reference, which are available on the Trust's website and on request.	None	DS		Audit Committee ToR/website
C.3.2b The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly.	The Members' Council has not been consulted on the terms of reference for the Audit Committee. The terms of reference are reviewed annually as part of the process to support the Annual Governance Statement and the Audit Committee's annual report to Trust Board. The terms of reference follow best practice as contained in the HFMA handbook.	As part of the annual reporting process by the Audit Committee to Trust Board, the Members' Council will be consulted on the Audit Committee's terms of reference.	DS/Chair of Audit Committee	January 2015	Members' Council/ Audit Committee minutes
C.3.2c The terms of reference should include details of how it will: ➢ monitor the integrity of the financial statements of the NHS foundation trust,	Audit Committee has terms of reference, which includes the areas listed.	None	DS/AF		Audit Committee ToR

Code provision	Current position	Action	Lead	When	Where
and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; ➢ review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; ➢ monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; ➢ review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; ➢ develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and ➢ report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.					
C.3.3 The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors	The Members' Council was involved in the appointment of new auditors in 2010 and the re-appointment in 2013. A governor with appropriate skills, knowledge and experience was involved in the process and interviews to appoint the auditor.	None	Chair of Audit/AF/ DS		AC minutes and MC papers and minutes

Code provision	Current position	Action	Lead	When	Where
on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.					
C.3.4a The audit committee should make report to the council of governors in relation to the performance of the external auditor, including detail such as the quality and value of the work and the timeliness of reporting and fees, to enable the council of governors to consider whether or not to re-appoint them.	This was done as part of the process to tender for external audit services and for consideration of the re-appointment of the auditor.	None	AF		Tender process
C.3.4b The audit committee should also make recommendation to the council of governors about to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.	This was done as part of the process to tender for external audit services and for consideration of the re-appointment of the auditor.	None	AF		Paper to Members' Council
C.3.5 If the council of governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Should such a situation occur, information to be provided to meet annual report timescales.	None	DS/AF		Annual report
C.3.6 The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three to five year period of appointment.	The length of appointment is considered as part of any tender process. Deloitte was awarded a contract for an initial period of three years in 2010 and this was extended, under the terms of the original tender exercise, for a further two years in 2013.	None	AF		Tender documents
C.3.7 When the council of governors ends an external auditor's appointment in disputed circumstances, the chair should write to Monitor informing it of the reasons behind the decision.	This would be done should such a situation occur.	None	Chair/AF		
C.3.8 The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant to raise, in confidence, concerns	The Trust has robust counter fraud processes in place. The Local Counter Fraud Specialist produces an annual plan and progress against this plan is reported	None	AF		LCFS documents

Code provision	Current position	Action	Lead	When	Where
about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	to the Audit Committee at each meeting. An annual report is also presented to the Committee. The Local Counter Fraud Specialist is proactive in raising awareness amongst staff regarding fraud and its reporting. Investigations undertaken and progress against these are reported to each Audit Committee meeting. This includes the Trust's arrangements in relation to the Bribery Act and assessment against the NHS Protect Qualitative Assessment. The Trust has a Whistleblowing Policy in place and is proactive in ensuring staff are aware of the policy and their responsibilities under it.		AGD		Whistleblowing Policy
C.3.9 A separate section of the annual report should describe the work of the committee in discharging those responsibilities. The report should include: - the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these were addressed; - an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of the external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and - if the external auditor provides non-audit services, the value of non-audit services provided and an explanation of how auditor objectively and independence was safeguarded.	Included in the annual report.	None	DS/AF		Annual report
SECTION D REMUNERATION					
D.1 The level and components of remuneration **Levels of remuneration should be sufficient to attract, retain and motivate directors of quality and with the skills and experience required to run the NHS**					

Code provision	Current position	Action	Lead	When	Where
foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for the purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy requirements.					
D.1.1 Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should follow the following provisions. ➢ Whether directors should be eligible for annual bonus in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of public and patients. ➢ Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate.; ➢ Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. ➢ The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	The Remuneration and Terms of Service Committee considers a performance-related pay scheme on an annual basis for Executive Directors. This includes challenging performance criteria both corporate and individual, which are aligned to the strategic objectives of the Trust, and strict parameters for any awards made.	None	Chair/ AGD		R&TSC minutes and scheme details
D.1.2 Levels of remuneration for the chair and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The Trust, with the agreement of the Members' Council, sets differential remuneration rates for Non-Executive Directors, the Chair of the Audit Committee and the Deputy Chair/Senior Independent	None	Chair/DS/ AGD		Papers to the Members' Council

Code provision	Current position	Action	Lead	When	Where
	Director, and the Chair of the Trust to reflect the difference in time commitment and responsibility in the respective roles. The Members' Council reviews the remuneration of the Chair and Non-Executive Directors annually with support from the Director of Human Resources and Workforce Development.				
D.1.3 Where an NHS foundation trust releases an executive director, for example, to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	This would be included in the annual report should the situation arise.	None	DS		Annual report
D.1.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligations to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	This would be actioned as appropriate by the Remuneration and Terms of Service Committee. The terms of reference of the Remuneration and Terms of Service Committee includes approval of any termination payments to the Chief Executive and Executive Directors and to ensure these are properly calculated and reasonable with regard to probity and value for money.	None	Chair R&TSC/ AGD		R&TSC terms of reference
D.2 Procedure **There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his/her own remuneration.**					
D.2.1 The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with	Remuneration and Terms of Service Committee in place. Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors (currently, although the terms of reference allow for a third) and the Chief Executive (non-voting). The Committee has terms of reference, available on request, outlining its role and the authority delegated to it by Trust Board. Any statement regarding use of	None	Chair/DS		R&TSC ToR

Code provision	Current position	Action	Lead	When	Where
the NHS foundation trust.	remuneration consultants would be made in the minutes as appropriate.				
D.2.2 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of 'senior management' for this purpose should be determined by the board but should normally include the first layer of management below board level.	Included in terms of reference for Remuneration and Terms of Service Committee.	None	Chair/DS		R&TSC ToR
D.2.3 The council of governors should consult external professional advisers to market-test the remuneration levels of the chair and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	The Members' Council set the Chair and Non-Executive Director remuneration on authorisation in May 2009. A process is in place for the Members' Council to assess, on an annual basis, whether a review of remuneration is required. This involves the use of an external consultant if the Members' Council thinks this is appropriate and the support of the Director of Human Resources and Workforce Development.	None	AGD/DS		Members' Council papers and minutes
SECTION E RELATIONS WITH STAKEHOLDERS					
E.1 Dialogue with members, patients and the local community **The board of directors should appropriately consult and involve members, patients, clients and the local community.** **The council of governors must represent the interests of trust members and the public.** **Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.**					
E.1.1 The board of directors should make available a public document that sets out its policy on the involvement of members, patients, and the local community at large, including a description of the kind of issues it will consult on.	The Trust currently has two strategies in place that outline its approach to the involvement of members, stakeholders, service users and carers, and staff (Involving People Strategy and Membership Strategy). The Membership Strategy has been reviewed on an annual basis and will be included in a wider community involvement strategy due for approval in the summer of 2014.	Development and approval of involvement strategy.	DS	Summer 2014	Trust Board minutes and intranet
E.1.2 The board of directors should clarify in	Included in E.1.1.	Development and approval of	DS	Summer	Trust Board

Code provision	Current position	Action	Lead	When	Where
writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums already in place (e.g. local Healthwatch, the Overview and scrutiny committees, the local League of Friends, and staff groups).		community involvement strategy		2014	minutes and intranet
E.1.3a The chair should ensure that the views of governors and members are communicated to the board as a whole.	The Chair would do this as appropriate.	None	Chair		
E.1.3b The chair should discuss the affairs of the NHS foundation trust with governors.	This is done through Members' Council meetings, informal briefings and development sessions. The Chair also updates, consults and, if necessary, seeks advice from the Lead Governor on a regular basis on issues affecting the Trust.	None	Chair		
E.1.3c Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors.	Non-Executive Directors are invited to attend Members' Council meetings and there is an expectation by the Chair that all members of Trust Board should do so, subject to other commitments.	None	Chair		
E.1.3d The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	Senior Independent Director is invited to all Members' Council meetings and the annual evaluation session.	None	DS		
E.1.4 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members that wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Support for the Members' Council to communicate with members is undertaken in a number ways. ➢ Information on Governors is on the Trust's website with details of how to contact individuals. ➢ The Members' Council has been featured in the members' magazine, 'Like Minds', again with contact details. ➢ A leaflet has been developed in conjunction with the Members' Council and this will be updated during 2014. ➢ Members' Council has a stand at	This is ongoing work through Members' Council.	DS	Ongoing	

Code provision	Current position	Action	Lead	When	Where
	members' events to meet their constituents. ➢ Governors have made personal links with dialogue groups. See also B.5.6a.				
E.1.5 The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of member opinion and consultations.	Included in the annual report.	None	DS/AF		Annual report
E.1.6 The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	Membership reviewed on a regular basis and any exceptions reported to Trust Board. Focus of recruitment activity is to maintain 1% level and ensure active and engaged membership, which is representative of the communities the Trust serves in Barnsley, Calderdale, Kirklees and Wakefield. Membership is reviewed as part of the development of the annual plan to Monitor and as part of the annual review of the Membership Strategy.	None	DS		Monitor annual plan/ performance report
E.2 Co-operation with third parties with roles in relation to NHS foundation trusts. **The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.**					
E.2.1 The board of directors should be clear as to the specific third part bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these bodies in order to discharge their statutory duties.	Under the conditions of its Licence, the Trust is required to co-operate with third party bodies. Although the detail of these bodies is no longer specified it is assumed that Monitor would require foundation trusts to continue to take Schedule 6 of the Trust's Terms of Authorisation into account.	None	DS		
E.2.2 The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and	Through the Chief Executive, the Trust ensures executive director attendance at key partnership and stakeholder meetings	None	CE		

Code provision	Current position	Action	Lead	When	Where
that collaborative and productive relationships are maintained with relevant stakeholder at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships and take steps to improve them.	as appropriate. Lead Directors are identified for relationship management with Monitor and the Care Quality Commission. The Trust has a seat on the Members' Council of Calderdale and Huddersfield NHS Foundation Trust and continues to seek representation on the Members' Council for Barnsley Hospital NHS Foundation Trust. A stakeholder review is undertaken by Trust Board on a regular basis.		DS/TB DS/Chair CE		

Trust Board 25 March 2014
Agenda item 8.4

Title:	**Monitor Licence**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that the Trust complies with the conditions of its licence issued by Monitor on 1 April 2013.
Vision/goals:	In support of its vision and goals, the Trust is required to meet certain regulatory, statutory and compliance requirements.
Any background papers/ previously considered by:	Initial risk assessment presented to Trust Board in March 2013 and internal audit report March 2014, which provided a substantial assurance opinion in relation to arrangements the Trust has in place to support the conditions of the provider licence.
Executive summary:	The licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which Monitor regulates providers of NHS services, both NHS and non-NHS. The final version of the licence was launched on 14 February 2013 following an extensive consultation. The provider licence is split into six sections, which apply to different types of providers. 1. General conditions – general requirements applying to all licensed providers. 2. Obligations about pricing – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff. 3. Obligations around choice and competition – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers. 4. Obligations to enable integrated care – enables the provision of integrated services and applies to all licensed providers. 5. Conditions to support continuity of service – allows Monitor to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services only. 6. Governance licence conditions for Foundation Trusts – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only. From 1 April 2013, all Foundation Trusts was automatically issued with a licence as the Health and Social Care Act 2012 specified that Foundation Trusts were to be treated as having met all the licence criteria. If Monitor wishes to make any changes to the licence it must first give notice to parties, including licence holders and clinical commissioning groups. If a proportion of licence holders (yet to be defined by the Department of Health, which has consulted on the matter) objects to the changes, the proposal must

	be referred to the Competition Commission. In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The following paper provides assurance to Trust Board that the Trust meets the conditions of its Licence, identifies potential areas of risk and includes the outcome of an internal audit completed in March on the Trust's compliance. From quarter 1, the exception report to Monitor will specifically refer to the Trust's compliance with the conditions of its Licence. Trust Board will be alerted to any exceptions or emerging risks through the quarterly reporting process.
Recommendation:	**Trust Board is asked to confirm that the report provides assurance that the Trust is complying with the Licence conditions, and to note any implications for the Trust as a result of being a licence holder.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Monitor provider licence

This paper builds on the paper presented to Trust Board in March 2013 and is intended to provide assurance that the Trust complies with the terms of its Licence. It sets out a broad outline of the licence conditions and any issues for Trust Board to note.

Internal audit undertook a review of the Trust's compliance with its Licence conditions and provided an opinion of substantial assurance. This will be reported formally to the Audit Committee in April 2014. There were five recommendations (four of low priority and one of medium) in relation to:

- developing a single co-ordinated mechanism to succinctly and explicitly capture the evidence and assurances to demonstrate compliance with the conditions (General Conditions G5 and G6);
- a formal articulation and publication of the patient eligibility and selection criteria the Trust employs (General Condition G8);
- do all it can to address its exclusion from the Calderdale Health and Wellbeing Board and to be actively engaged in discussions with CCGs to ensure appropriate governance of Better Care Fund budgets (Integrated Care Condition IG1);
- ensure compliance with the conditions of the provider licence is more explicit in the Assurance Framework (Continuity of Services Condition CoS3);
- ensure that, once available, Monitor's requirements in relation to costing and pricing are built into projects designed to improve these systems (Pricing Conditions P1 to P3).

Condition	Provision	Comments
General licence conditions (G)		
1. Provision of information	Obligation to provide Monitor with any information it requires for its licensing functions.	The Trust is currently obliged to provide Monitor with any information it requires and, within reasonable parameters, to publish any information Monitor requires it to. Formal articulation of this Condition, therefore, should not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome. Monitor has suggested it may conduct a regulatory impact assessment if it expects a significant impact as a result of this condition.
2. Publication of information	Obligation to publish such information as Monitor may require.	

Condition	Provision	Comments
3. Payment of fees to Monitor	Gives Monitor the ability to charge fees and for licence holders to pay them.	Monitor currently has no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for additional fees and this would, therefore, become a cost pressure.
4. Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	As part of the recommendations emerging from the Francis Report, Monitor and the Care Quality Commission have been tasked with providing guidance/rules around what constitutes a 'fit and proper' person. Monitor has included some guidance in the revised Code of Governance; however, this reflects the conditions the Trust already has in place. Whilst any 'rules' would be relatively easy to apply to Directors through a recruitment process, it would be more difficult to apply to governors given the element of self-selection through the election process. In exceptional circumstances, the Trust can make representation to Monitor to agree that a person who does not meet the fit and proper persons test can remain or be appointed. When guidance is published, the Trust will ensure it does all it can to ensure fit and proper persons become Directors or governors.
5. Monitor guidance	Requires licensees to have regard to Monitor guidance.	The Trust is currently obliged to have regard to Monitor guidance.
6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The internal audit report recommends that the Trust develops a single co-ordinated mechanism to succinctly and explicitly capture the evidence and assurances to demonstrate compliance with the conditions. This has been agreed and will be co-ordinated by the Director of Corporate Development.
7. Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify Monitor is their registration is cancelled.	The Trust is registered with the Care Quality Commission.
8. Patient eligibility and selection criteria	Requires licence holders to set transparent	The internal audit report recommends that the

Condition	Provision	Comments
	eligibility and selection criteria for patients and apply these in a transparent manner.	Trust formally articulates and publishes the patient eligibility and selection criteria it employs. This has been agreed and the Trust will include a statement on its website linked to further work to develop service directories for each BDU.
9. Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all mandatory services and "any other service which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS)." See CoS1.
Pricing conditions (P)		
1. Recording of information	Obligation of licensees to record information, particularly about costs.	Monitor requirements in relation to pricing information are still being developed, particularly for care that currently falls outside of the national tariff. However, the Trust will need robust clinical recording systems, capable of producing accurate patient-level costings. The internal audit report recommends (as a performance improvement opportunity) that the Trust ensures that, once available, Monitor's requirements in relation to costing and pricing are built into projects designed to improve these systems and the Trust has noted the recommendation.
2. Provision of information	Obligation to submit the above to Monitor.	
3. Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	The Trust is working with its commissioners on the implications of the requirements to develop a local tariff within the terms of national guidance. The Trust has a memorandum of understanding in place with commissioners relating to the introduction of tariffs for mental health aimed at ensuring the Trust, as a provider, is not de-stabilised when tariff is introduced. The Trust has been using mental health currencies since 2012 and will continue to do so. This will improve baseline information and enable a better understanding of the impact of the tariff. This is an area of risk for the Trust in terms of assessing the implications for the Trust's income, and data quality and recording.

Condition	Provision	Comments
5. Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to Monitor for a modification.	See P4 above.
Choice and competition (C)		
1. Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	Choice is not yet mandatory in mental health service.
2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures. There is a risk to the Trust that challenges on competition could restrict or block service re-design or improvements.
Integrated care condition (IC)		
1. Licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care	Includes a patient interest test, which means that the obligations only apply to the extent that they are in the interests of people who use health care services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care. The internal audit report recommended that the Trust does all it can to address its exclusion from the Calderdale Health and Wellbeing Board and to be actively engaged in discussions with CCGs to ensure appropriate governance of Better Care Fund budgets. The Trust will continue to work with partners in Calderdale to ensure its place in ongoing strategic plans and is actively engaged with CCGs in relation to the Better Care Fund.
Continuity of service (CoS)		
1. Continuing provision of commissioner requested services	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant	All mandatory services were automatically considered as CRS from 1 April 2013. CCGs have a three-year period (i.e. to the end of the 2015/16

Condition	Provision	Comments
	commissioners.	financial year) to review this designation. The process for foundation trusts to appeal inappropriate designations will be restricted during this period, which means that providers will only be able to appeal a designation where the contract for that service is coming to an end and they wish to cease provision. For providers that have more than one commissioner, agreement on commissioning across the piece becomes a much bigger issue. There will be a need to ensure commissioners are fully engaged in the service transformation agenda as this has the potential to be deemed a breach of continuing provision.
2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in CRS and to seek Monitor's consent before disposing of these assets IF Monitor has concerns about the licensee continuing as a going concern.	As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek Monitor's consent for disposal of assets if Monitor was concerned about its ability to continue as a going concern.
3. Monitor risk rating	Licensees are required to have due regard to adequate standards of corporate governance and management.	The Trust has robust and comprehensive corporate governance arrangements in place. The internal audit recommendation to ensure compliance with the conditions of the provider licence is more explicit in the Assurance Framework will be taken forward in the review of corporate objectives and the assurance framework for 2014/15.
4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to	Does not apply to the Trust.

Condition	Provision	Comments
	breach its licensing conditions.	
5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	Further guidance on this is awaited from Monitor. It could have the potential to bring significant further financial burden on providers.
6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with Monitor.	The Trust is aware it would need to co-operate with Monitor in such circumstances.
7. Availability of resources	Requires licenses to act in a way that secures resources to operate CRS.	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services.
Foundation Trust conditions		
1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to Monitor.	See G1. The Trust is currently obliged to provide Monitor with any information it requires, including information to update its entry on the register of NHS foundation trusts.
2. Payment to Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by Monitor.	Monitor has undertaken not to levy any registration fees on foundation trusts without further consultation.
3. Provision of information to advisory panel	Monitor has established an advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The Advisory Panel was established in April 2013 and the Trust provided a briefing on the Panel for the Members' Council. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Members' Council.
4. NHS Foundation Trust governance arrangements	Gives Monitor continued oversight of the governance of foundation trusts.	The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. A consultation on governance reviews, which trusts would be required to undertaken every three years, has just ended and final guidance is awaited.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 25 March 2014
Agenda item 9

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 December 2013 in respect of: - transfer of title for Laura Mitchell House, Halifax, between the Trust and Calderdale and Huddersfield NHS Foundation Trust; - a contract for the sale of freehold land with vacant possession at Laura Mitchell House, Halifax, between the Trust and Calderdale and Huddersfield NHS Foundation Trust; - provision of security services at Laura Mitchell House, Halifax, between the Trust and Ad Hoc Property Management Limited; and - a deed of trust relating to the Trust's bank account between Atlantic Data Limited and the Trust; - provision of court mental health treatment requirement services between West Yorkshire Probation Trust and the Trust.
Recommendation:	**Trust Board is asked to note the use of the Trust's seal since the last report in December 2013.**
Private session:	Not applicable