With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (public session)
Tuesday 24 June 2014 at 11:30
Rooms 49/50, Folly Hall, Huddersfield

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 29 April 2014

4. Chief Executive's report (verbal item)

5. Assurance from Trust Board Committees

5.1 Clinical Governance and Clinical Safety Committee 15 April and 13 May 2014 and 9 June 2014 (verbal)
5.2 Mental Health Act Committee 13 May 2014
5.3 Remuneration and Terms of Service Committee 1 April 2014
5.4 Audit Committee 8 April and 23 May 2014

6. Annual report, accounts and Quality Accounts 2013/14

7. Performance reports month 2 2014/15

7.1 Section 1 – Performance report month 2 2014/15 (to follow)

7.2 Section 2 – Finance report month 2 2014/15 (to follow)

7.3 Exception reporting and action plans

(i) Customer services annual report 2013/14
(ii) Medical re-validation annual report
(iii) Hard Truths staffing commitments

8. Corporate Governance Statement

9. Calderdale hub business case

10. Use of Trust seal

11. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 22 July 2014 in Conference Room 3, Al-Hikmah Centre, Batley, WF17 7AA.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 2

Title:	**Declaration of interests by the Chair and Directors of the Trust**
Paper prepared by:	Director of Corporate Development on behalf of the Chair of the Trust
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	Annual declaration made by the Chair and Directors of the Trust March 2014.
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, received in March 2014, and the requirement for the Chair and Directors to consider and declare any interests at each meeting. There are no legal implications; 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. The following declarations have been made. Peter Aspinall – Member, Disciplinary Pool, Institute and Faculty of Actuaries. Laurence Campbell – Treasurer and Trustee, Kirklees Citizens' Advice Bureau and Law Centre. Steven Michael – Member, Academic Advisory Council, International Institute of Organisational Psychological Medicine
Recommendation:	**Trust Board is asked to consider the above Declarations and, subject to any comment, amendment or other action, to formally note the details in the minutes of this meeting.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 29 April 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
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
In attendance:	Adrian Berry	Director, Forensic Services
	Laurence Campbell	Non-Executive Director (designate)
	Bronwyn Gill	Head of Communications
	Sean Rayner	District Director, Barnsley and Wakefield
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Director, Calderdale, Kirklees and Specialist Services
	Robert Toole	Finance management consultant
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Tim Breedon	Director of Nursing, Clinical Governance and Safety
Guests:	Stephen Baines	Governor, Members' Council (appointed, Calderdale Council)
	Colin McIlwain	NHS England
	Bob Mortimer	Governor, Members' Council (publicly elected, Kirklees)
	Michael Smith	Governor, Members' Council (publicly elected, Calderdale)
	Tony Wilkinson	Governor, Members' Council (publicly elected, Calderdale)

TB/14/19 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. He particularly welcomed Laurence Campbell (LC) who, subject to the approval of the Members' Council, will take up post as a Non-Executive Director on 1 June 2014 replacing Bernard Fee (BF) on Trust Board. IB thanked BF on behalf of Trust Board for his contribution to and support of both Trust Board and the Trust. Trust Board will very much miss his challenge and customer focus, which has helped the Trust enormously over the last six years and has had a big influence on the Trust and, in particular, on Trust Board papers.

TB/14/20 Declaration of interests (agenda item 2)

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

TB/14/21 Minutes of and matters arising from the Trust Board meeting held on 25 March 2014 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 25 March 2014 as a true and accurate record of the meeting.

There was one matter arising.

TB/13/67 Specialist services commissioning

The Chief Executive (SM) informed Trust Board that the Trust had received information from the South Yorkshire and Bassetlaw Area Team setting out the national funding position for all specialised services, including secure mental health provision. Nationally, there is a £693

million gap between allocated funding and the value of contracts agreed, though not signed, with providers for 2014/15. The Treasury has agreed £400 million of non-recurrent support but this leaves an in-year deficit of £293 million and a recurrent gap for 2015/16 of £693 million. The impact for Yorkshire and Humber is a deficit of £31 million in-year and a recurrent underlying deficit of £61 million. This represents a recurrent deficit of 5.1% of the area team's allocation for specialised commissioning.

Commissioners are intending to re-visit contract offers with all providers over the next two weeks with a view to signing contracts by 9 May 2014 at which point the £31 million gap for 2014/15 must be closed. The Trust has been informed that the potential allocation of contract reduction for its adult secure services amounts to £613,000 for 2014/15 and that, although there are a number of QIPP schemes identified by commissioners, no costed plans have been produced. The Trust is currently working through a range of mitigating actions as well as seeking further clarity from NHS England as to the basis of the contract reduction.

TB/14/22 Audit Committee annual report to Trust Board (agenda item 4)

It was RESOLVED to RECEIVE the annual report from the Audit Committee and to SUPPORT the view that the Committee can provide assurance on the effectiveness of Trust Board Committees, management of risk, that Committees meet their terms of reference and that their work programmes are aligned to the risks and objectives of the Trust.

TB/14/23 Stakeholder analysis (agenda item 5)

In introducing this report, SM commented that it demonstrates how the Trust is working with different partners and the importance of this work. Work with clinical commissioning groups (CCGs) is increasing in prominence and is becoming harder to cover at senior level across the four districts and specialist services. The Trust is also facing an increase in the information requested to inform CCG agendas.

Julie Fox (JF) asked why 'regulators' were seen to have both high influence and high power. SM responded that the implications of Regulator interest in partner Trusts and the Care Quality Commission (CQC) revised inspection regime determines the high level of importance to the Trust.

Following a question from IB in relation to the position of specialist commissioning as a key external issue, the following comments were made during the discussion.

- SM agreed that the position does represent a key external issue providing a significant risk to the Trust. It was noted that the Trust has been highlighting these issues at a national level over the past year; however, the Trust was advised of this after submitting its two-year plan to Monitor.
- Although not expecting an immediate answer, BF suggested the Trust should consider use of its estate. Adrian Berry (ABe) responded that, if services are de-commissioned, the Trust would have to consolidate services and make best use of the estate it has. Alex Farrell (AF) added that the Trust's five-year plan will include a commercial rationale and strategy for each service line, which will set out the Trust's approach.
- Jonathan Jones (JJ) asked how this would be picked up in the annual plan given the revenue 'hole' now facing the Trust. AF responded that the Trust needs to consider different scenarios, risks, the likelihood of risks materialising and an assessment of the worst-case scenario. She added that all providers will have a similar level of challenge.
- JJ asked if there was still an opportunity to lobby and influence. SM responded that the Trust continues to do so through trade bodies. BF commented that the decision appears

to have already been made and that alternative areas for cuts may be unpalatable for NHS England.

- SM commented that the Trust needs to be creative in its approach and there are opportunities within the market for growth. Discussion has begun with regional partners on shared pathway approaches, which would present opportunities for the Trust to work in partnership with other providers in a networking arrangement.
- He added that the reality is that this service involves a group of very vulnerable and sometimes very dangerous patients and any risk assessment will include consideration of increased clinical risk.

It was RESOLVED to NOTE the update, issues arising and mitigating action being taken.

TB/14/24 Delivery of two-year operational plan (agenda item 6)

SM commented that transformation has not taken place at the pace the Trust would have wanted in 2013/14. The coming year will lay the foundations to fully deliver transformational change in 2015/16. The two-year plan provides for management action at a Trust-wide level, determined centrally, which is unsustainable going forward. Transforming services will reflect the themes from engagement events, which underpin the plan. Getting the cost-base right is an absolute priority for 2014/15, laying the foundation for delivery of efficiency savings in 2014/15 and transformational delivery in 2015/16. More detail is needed for 2015/16 and for the five-year strategic plan. AF added that Monitor, in its feedback on the Trust's two-year plan, challenged the Trust on its delivery of the cost improvement programme, wanting assurance and clarification of arrangements for risk management. This provides the Trust with the time to develop a robust response in its five-year plan. In response to JJ's question, SM responded that other Trusts are in a similar position but some are finding the challenge difficult.

Peter Aspinall (PA) sought assurance that, if there is a shortfall in the cost improvement programme towards the end of the year, the Trust will be aware and able to manage expectations. SM responded that there would be a very strong and robust connection between planning, operations and delivery in 2014/15 to ensure the plan is met.

Nisreen Booya (NHB) commented that the Trust's plan represents a new mind-set for staff. The Trust will need to prepare the ground for a workforce that will work in a different way and for service users in terms of self-direction and self-care.

JJ commented that the cost improvement programme was unlikely to deliver to plan and, therefore, has to be monitored and managed, reacted to and be flexible, with Trust Board working together to make difficult decisions.

Helen Wollaston (HW) commented that it was very important that the Trust has a communications plan in place around its plans, transformation and its cost improvement programme.

TB/14/25 Performance reports month 12 2013/14 (agenda item 7)

TB/14/25a Quality performance report (item 7.1)

Karen Taylor (KT), on behalf of Tim Breedon (TB), commented that changes will be made to the report in 2014/15 to reflect the comments made by Trust Board and, to meet the Hard Truths commitment, the Trust will publish staff data by the end of June 2014. IB then invited comments and questions from Trust Board.

JF commented that performance against the target for the proportion of service users offered a care plan, although it has improved, continues to be poor. She commented that it was surely straight forward and simple to address.

IB asked for a comparison with other Trusts for the 'friends and family' test.

PA asked what the plan was for achievement of the 14-day access target and whether this would be achieved by quarter 1. KT responded that there is a plan in place to achieve the target. She accepted there are issues within services and acknowledged that improvement is needed. Targeted action is underway and the plan is to achieve the target by quarter 2. NHB added that review of assessment arrangements will be part of the transformation programme to provide one assessment for service users, which will improve the service provided and go some way to improving performance. AF also added that this is an arbitrary commissioner target and there is agreement with commissioners to review the capacity commissioned and resources available to achieve the target.

TB/14/25b Finance report month 12 2013/14 (item 7.2)
AF highlighted the following.

- Draft accounts were submitted to Monitor on 23 April 2014.
- The Trust has a surplus position of £3.8 million, which is £33,000 ahead of plan.
- Additional information on the cost improvement programme has been included in the report at the request of Trust Board.
- The financial risk rating remains at 4 against a plan of 4.
- The additional analysis of the run rate will continue in 2014/15.

BF asked if any of the cost saving substitutions were recurrent. AF responded that some are a question of timing and some are recurrent changes found as alternatives by BDUs. Of the £1.5 million, £500,000 is non-recurrent with the rest recurrent and rolling into the 2014/15 plan. She also explained that the difference of £2 million in income is due to the delay in opening ten additional beds at Newton Lodge, CQUIN performance and underspend for on provisions offset by release of provisions.

TB/14/25c Strategic human resources report Q4 2013/14 (item 7.3)
Alan Davis (AGD) highlighted the following.

- The report has been considered in detail by the Remuneration and Terms of Service Committee.
- The sickness absence target was not achieved although significant improvements were made in a number of areas. The Trust will continue with this ambitious target in 2014/15.
- The Trust is required to survey staff every quarter in relation to the 'friends and family' test. The Trust is in a good position through the wellbeing survey to implement this requirement.
- He also stressed the importance of communications to staff on Trust plans and transformational change.

JF was concerned that 38% of staff said they have experienced bullying and she asked what the Trust was doing about this. AGD responded that this is a recurring theme and there has been discussion with staff side; however, the survey is not substantiated in the form of cases reported. In conjunction with staff side, the Trust will develop a framework around harassment and bullying focusing on changes in culture to handle relationships. HW added that a more detailed report will be presented to the Remuneration and Terms of Services Committee.

JJ asked how the sickness absence rate compared to previous years. AGD responded that it was 5.3%, showing an improvement. JJ also asked how the Trust engaged and communicated with staff in respect of the cost improvement programme. AGD responded that the Trust has a good relationship with staff side and meets regularly to discuss the Trust's financial position in addition to formal meetings. Staff side is very supportive of Trust plans and its position, and understands that difficult decisions are needed and the context for these. The Trust has been open and honest with staff, remaining true to its values. It is also intended to run another round of Middleground to focus on the coming challenge involving senior staff and clinicians. The key message is that the solution belongs to all staff not just Directors. IB commented that Trust Board is invited to attend the planned engagement events for staff, which provides an excellent way to find out staff views.

PA asked whether the Trust is adopting a 'one size fits all' approach to staff engagement or whether it would be tailored to different groups and levels. AGD responded that the Trust has a range of engagement mechanisms in place for staff and a different range of feedback arrangements for staff to express their views. It is very much not a case of one approach. The wellbeing survey shows that staff have confidence in Trust processes compared with other organisations. He would like to see higher response rates; however, the Trust does benchmark well against other organisations.

BF commented that there must be clear message for engagement as the Trust will lose the confidence of staff if messages change later in the year. SM confirmed that communication will be an iterative process. The Trust has been open and honest about the scale of the challenge and what this means for staff, and will continue to be so; however, staff also have a responsibility to ensure they too understand the Trust's position and implications, and how they can contribute to the Trust's future, such as improvements in sickness absence.

IB asked BDU Directors to highlight their key concerns.

Sean Rayner (SR) highlighted the external environment in relation to public health in Barnsley and Wakefield. Health and wellbeing services are likely to be tendered over the next 18 months with a much reduced resource envelope available. KT commented that financial pressures within local authorities mean the Trust has to work in a different way in terms of integration. She also highlighted the continued risks associated with children's and adolescents' mental health services. ABe highlighted the specialist commissioning agenda and the plan for re-procurement of services in the next twelve months. He also commented on the reduction in sickness absence in low secure services, which reflects management action taken in the last twelve months and which shows a genuine downturn in long and short-term absence.

<u>TB/14/25d Exception reports and action plans – Risk assessment of performance targets, CQUINs and Monitor Risk Assessment Framework (item 7.4(i))</u>
AF highlighted three areas.

- The Trust will continue to monitor compliance with the Trust's licence conditions and the implications of the Care Quality Commission inspection regime.
- The introduction of extended legal rights of choice for mental health services has implications for the Trust and it is not yet known how this will operate in practice.
- The potential financial consequence is estimated at a £500,000 risk to income with £45,000 associated with data quality.

SM commented that there would be a workshop for Trust Board on the revised CQC inspection regime in the next few months and that his and NHB's experience of involvement in inspections would be very helpful. There has been no confirmation of when the Trust will be inspected; however, it will be before January 2016.

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

TB/14/25e Exception reports and action plans – Equality report (item 7.4(ii))
Dawn Stephenson (DS) explained the focus for the coming year for meeting the Equality Delivery System 2. Workshops for staff and service users will be organised to develop plans to ensure the Trust moves from 'developing' to 'achieving' status to meet EDS2 outcomes. Trust Board was supportive of this focus.

HW commented that she would like to see BDUs challenged to move from 'developing' to 'excelling' over the next three years to ensure Trust services meet the needs of individuals with protected characteristics. AF commented that the paper contained a very commendable set of ambitions. The performance trajectory must link to the Quality Improvement Strategy and reflect areas where the Trust needs to focus across all services that can be influenced and addressed within the three-year timescale. JF added that the Trust could learn from other organisations that are further forward.

It was RESOLVED to RECEIVE the Equality Report for 2013/14 and to NOTE the work undertaken to date and the further development required.

TB/14/25f Exception reports and action plans – Quarterly serious incidents report (item 7.4(iii))
KT raised the following.

- The serious incidents annual report will come to Trust Board in June 2014.
- There has been a continued increase in incidents due to changes in reporting requirements in relation to pressure ulcers. The Trust will review the requirements and its own reporting practice in the coming quarter.

IB asked that the annual report includes more analysis of the incidents relating to pressure ulcers and the action the Trust is taking to reduce these incidents as this has not previously been included in the comparative data.

It was RESOLVED to NOTE the report.

TB/14/25g Exception reports and action plans – Customer services quarterly report (item 7.4(iv))
The following comments were made in relation to the report.

- JF commented that this was a good report and well presented. She thought it would be useful to see the equality data presented in relation to people who use services as a whole.
- HW queried the 'responding in a timely manner' data and DS explained that some responses extend over two reporting periods.
- IB mentioned that he had been involved in looking again at a small number of the Trust's most serious complaints. He was pleased to note the process of peer review by practising clinicians, that the processes in place are robust and that the organisation is willing to apologise and say sorry when necessary. He appreciated that the current approach to data protection will be increasingly difficult to maintain especially as regards carers and service users.
- AF commented that the Trust appears to be receiving more compliments and suggested that the Trust should also try to capture thank you letters sent to individual members of staff.
- BF thought that a comparison with last year and trend analysis would be useful in the report. DS agreed this would be included in the annual report.

It was RESOLVED to NOTE the report.

TB/14/26 Monitor quarter 4 return (agenda item 8)

It was agreed to add the impact of specialist commissioning intentions. Subject to this addition, **it was RESOLVED to APPROVE the return.**

TB/14/27 Assurance Framework and organisational risk register (agenda item 9)

It was agreed to add the following risks:

- specialist commissioning position;
- development of the Better Care Fund and implications for Trust services in terms of parity of esteem and a balanced and proportionate approach to mental health.

It was RESOLVED to NOTE the assurances presented, NOTE the areas with gaps identified and NOTE the key risks.

TB/14/28 Date and time of next meeting (agenda item 10)

The next meeting of Trust Board will be held on Tuesday 24 June 2014 in rooms 49/50, Folly Hall, Huddersfield.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 15 April 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
	Dawn Stephenson	Director of Corporate Development
Apologies:	None	
In attendance:	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance
	Sean Rayner	BDU Director, Barnsley and Wakefield
	Karen Taylor	BDU Director, Calderdale, Kirklees and specialist services

CG/14/20 Welcome, introduction and apologies (agenda item 1)

The Chair (HW) welcomed everyone to the meeting, particularly Sean Rayner (SR) and Karen Taylor (KT) attending the Committee to provide an operational perspective to the items considered by the Committee.

CG/14/21 Minutes of the previous meeting held on 11 February 2014 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 11 February 2014.

CG/14/22 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) confirmed that a recruitment exercise is underway for the Chief Pharmacist post. Shortlisting took place on 7 April 2014 with interviews to be held later in April. A key part of the role will be to develop and implement a revised Pharmacy Strategy. The new Chief Pharmacist will be asked to present the Strategy to the Committee in early 2015. In the meantime, it was agreed to ask Sarah Hudson, acting Chief Pharmacist, to update the Committee in June 2014 on the implementation of the actions arising from the 2012 internal audit.

Action: Nisreen Booya to follow up

AC/13/91 Update on the meeting with MIND regarding prone restraint (agenda item 3.2)

Included in agenda item 10.6.

AC/14/17 Care Quality Commission revised inspection arrangements

The Chair of the Trust has agreed a session for the full Board when the Trust has been advised of its inspection date.

CG/14/23 Impact of cost improvement programme on Trust services and quality impact process and outcome for 2014/15 (agenda item 4)

Tim Breedon (TB) explained that there had been a full quality impact assessment undertaken on the cost improvements included in the two-year operational plan. A detailed

analysis of the implications of the workforce efficiencies (mandatory training headroom and shift patterns) will be completed by the end of May and end of April respectively. A summary of the outcome by Business Delivery Unit (BDU) will be presented to the Committee in June 2014. Alan Davis (AGD) also queried the travel figure in the summary report, which TB agreed to check.

Action: Tim Breedon

CG/14/24 Staffing level reviews and reporting (agenda item 5)

The Committee received a tabled paper as the guidance arising out of Hard Truths, the Government's final response to the Francis Report, has only just been issued. The paper set out the Trust's current position and next steps. Bernard Fee (BF) commented that the Trust needs a quick analysis of what it has currently in terms of the right number of staff in the right area at the right time. TB responded that it was intended to present a paper to Trust Board in June 2014, which would cover this for in-patient services. The Committee asked if this analysis could be extended to cover community services. It was agreed that the paper would cover in-patient services from the end of May 2014 and a timescale for community services.

Action: Tim Breedon

CG/14/25 Serious incidents quarterly report (agenda item 6)

The Committee noted that a further analysis of incidents will be included in the annual report to be presented to Trust Board in June 2014. HW asked that themes and how these have been addressed and mitigated are drawn out in the report.

Action: Tim Breedon

The paper presented on pressure ulcer incidents explained a reactive, preventative approach; work has begun on improvement action, which will be presented to the Committee with timescales for improvement in the number of incidents reported.

Action: Tim Breedon

CG/14/26 Unannounced visits (agenda item 7)

Karen Holland (KH) confirmed that the 2014/15 programme has started and four visits have taken place. No major risks or issues are emerging to raise with the Committee.

CG/14/27 Health and safety update (agenda item 8)

Health and safety objectives 2014/15 (agenda item 8.1)

The Committee noted the objectives and the three key risk areas around managing aggression and violence, slips, trips and falls, and stress. The action plan has been designed to strengthen how the Trust addresses risk at local, BDU level.

Outcome of self-assessment against national audit tool for security of medicines (agenda item 8.2)

The report and action plan were noted.

CG/14/28 Internal audit reports (agenda item 9)

Trust approach to Francis (agenda item 9.1)

TB took the Committee through the findings and recommendations of the report, which provided substantial assurance.

Infection prevention and control (agenda item 9.2)
TB took the Committee through the findings and recommendations of the report, which provided moderate assurance. An update on the action plan will be provided at the November 2014 meeting.

Action: Tim Breedon

CG/14/29 Sub-groups (agenda item 10)

Incident Review Panel
No issues to raise. Meetings have been scheduled to fit with meetings of this Committee.

Drugs and therapeutics
No issues to raise.

Health and safety
AGD reported that staff side has raised an issue around the grading of attacks on staff. An audit will be commissioned and a detailed review of a selection of amber/red incidents undertaken to assess the appropriateness of the grading.

Infection Prevention and Control
The report was noted.

Safeguarding
The report was noted.

Managing aggression and violence
TB reported on a constructive and helpful meeting with MIND. The Trust appears to be in a good position in comparison with other Trust, particularly in relation to engaging service users and carers; however, MIND would like to see more involvement of service users and carers in training and the planning of training.

CG/14/30 Children's services (agenda item 11)

SR updated the Committee on the work of the Stronger Families Team. Questions were raised in relation to the contribution made to the Trust and the benefits it brings to individuals who use Trust services.

SR also updated on two concerns raised by the Committee at February's meeting.

In relation to Greenacre School, SR explained that, as part of the transfer from the local authority to the Trust, an external report was commissioned and an action plan developed to address the concerns raised. The public health team at Barnsley Council is also developing a revised service specification for the service provided into Greenacre School and it is likely to recommend that the service should be provided by a specialist paediatric nursing team, such as the one in place at Barnsley Hospital NHS Foundation Trust.

In relation to the OfSTED report on school nursing, an external report was commissioned following the death of child K. An action plan is in place to support cultural change within the service.

In relation to children's and adolescents' mental health services (CAMHS), KT outlined the actions to address the key areas of:

- access to Tier 4 services;

- waiting times;
- children's and young people's IAPT services;
- out-of-hours provision;
- performance; and
- managerial and operational management structures.

KT advised the Committee that it would take at least twelve months and possibly up to two years to deliver the recovery plan in full.

BF commented that he would find it useful to receive a financial overview of children's services provided by the Trust as a whole, including contribution and cost to the organisation, and the benefits providing these services brings to the Trust. The Committee agreed it would also be useful to identify measures of success, such as, positive impact on prevention and health and wellbeing. It was agreed to include this in the update report on the recovery plan at the June 2014 meeting.

Action: Karen Taylor

CG/14/31 Use of Bed Management Protocol (agenda item 12)

SR and KT assured the Committee that progress has been made but acknowledged that there was more work needed to ensure consistency across the Trust. AGD commented that there is both a short-term issue in how the Trust is managing the current issues and a longer-term issue, which reflects the need to transform services. He would take more assurance from an interim position managed in the right way with contingency plans in place across the Trust to identify and manage bed shortages. Emergencies should be exceptional circumstances; other issues are part of day-to-day business continuity management. NHB commented that this reflects the wider need for the transformation of the acute care pathway and in particular, the crisis and home-based treatment service, for which a cross-Trust consistent approach is needed. KT agreed to take the comments away for consideration.

Action: Karen Taylor

CG/14/32 Transformation programme - dementia (agenda item 13)

Presentation from Suzanne Wightman on the progress towards transforming dementia services.

CG/14/33 Quality Improvement Plan (agenda item 14)

TB commented that this will form the basis of and support for reporting to Trust Board in 2014/15. It will also translate into local BDU plans and development of plans at service line level led by Practice Governance Coaches.

CG/14/34 Quality Accounts 2013/14 (agenda item 15)

TB updated on the current position and consultation with stakeholders. He confirmed that the actions against the recommendations from Deloitte for 2012/13 are complete.

CG/14/35 BDU Governance Groups report (agenda item 16)

The report was noted.

CG/14/36 Date of next meeting (agenda item 17)

The next meeting will be held on Tuesday 13 May 2014 at 12 noon in the Wainhouse room, 5th floor, F Mill, Dean Clough, Halifax, to consider and approve the Trust's Quality Accounts for 2013/14. The next full Committee meeting will be held on Tuesday 10 June 2014 at 14:00 in room 52, Folly Hall, Huddersfield.

CG/14/37 Any other business

NHB commented that she would find it useful to receive a report on the Trust's strategy in relation to supporting people from black and minority ethnic communities. She expressed a concern that the quality of service to these communities provided by the Trust was not as good as that previously provided as the Trust no longer provides specialist services. HW agreed to raise this with Dawn Stephenson.

Action: Helen Wollaston

HW also thanked BF for his contribution and support for the Committee and wished him well following his 'retirement' from Trust Board.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 13 May 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
	Dawn Stephenson	Director of Corporate Development
Apologies:	Alan Davis	Director of Human Resources and Workforce Development
In attendance:	Karen Batty	Assistant Director, Practice Governance
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Steven Michael	Chief Executive

CG/14/38 Welcome, introduction and apologies (agenda item 1)

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

CG/14/39 Quality Accounts 2013/14 (agenda item 2)

Tim Breedon (TB) introduced this item. He reminded the Committee of the positive response from Deloitte last year. The Quality Accounts for this year have been developed as a result of this feedback and build on the recommendations made by Deloitte. A key recommendation was that a more detailed draft report is presented to the Committee, which has been achieved.

He also reported a positive response from the Calderdale, Kirklees and Wakefield Quality Board (commissioners) on the draft report. The report is seen as transparent, open and honest. The four commissioners will produce a joint response. TB commented that the principle of the report is openness and honesty, particularly in relation to the Trust's performance.

Following today's meeting, the comments from the Committee, the Chair of the Trust and the Members' Council Quality Group will be included. The comments from stakeholders and partners will be followed up for the final report at the Audit Committee on 23 May 2014.

HW reminded the Committee that the purpose of this meeting was to focus on the substance of the report. Any editorial comments should be passed to Karen Batty (KB) separately.

The following detailed comments were made.

- Bernard Fee (BF) suggested including in the introduction the wider context and challenge facing the Trust in delivering its services.
- The Members' Council Quality Group commented that it would like to see how the Trust develops its staff through performance measures under Priority 6.
- Narrative to be included on limited/no assurance internal audit reports to demonstrate how the Trust has addressed weaknesses in its systems.
- Summary narrative to be included on areas of achievement and of areas where CQUINs have not been achieved to demonstrate what the Trust has done to address non-achievement.
- The Committee noted the issue in relation to 7-day follow up, which has been referred to Monitor. The issue relates to definition of the group to be measured. Deloitte is supportive of the Trust's position and the Trust is currently awaiting the outcome of

Monitor's consideration of the issue. If the Trust is required to re-state its performance against the target, it will need to explain the position in the Quality Accounts in terms of non-achievement in quarters 1, 2 and 3 of 2013/14. It was agreed to have a statement prepared once Monitor's view is known.

- Narrative to be included on the increase in re-admission rates.
- Julie Fox (JF) suggested setting out abbreviations in full on first appearance in each section for clarity for the reader.
- Narrative to be included under Priority 1 in relation to the seriousness with which the Trust takes the outcomes and what the Trust is doing to address areas of weaker performance.
- Further explanation is to be provided for access and referrals target achievement to demonstrate the improvement over last year.
- More detailed narrative to be included on care plans.
- An explanation of 'cluster review' to be included under Priority 4 and an explanation provided on the variation in performance month-on-month.
- Under Priority 5, if the Trust is required to re-state its position on 7-day follow up, it was suggested that both sets of figures are included.
- Under Priority 6, it was agreed to highlight the significant progress the Trust has made on sickness absence.
- HW suggested inclusion of a small number of quotes or vignettes if guidance permits.

It was RESOLVED to APPROVE the final draft of the Quality Accounts for 2013/14 subject to inclusion of outstanding comments and any issues raised at the Audit Committee on 23 May 2014. The Committee recognised that there may be some amendments required if Monitor requires the Trust to re-state its 7-day follow up figures.

CG/14/40 Date of next meeting (agenda item 3)

The next meeting will be held on Monday 9 June 2014 at 10:00 in training room 1, Learning and Development Centre, Fieldhead, Wakefield.

Minutes of Clinical Governance and Clinical Safety Committee held on 9 June 2014

Present:	Ian Black	Chair of the Trust
	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
	Dawn Stephenson	Director of Corporate Development
Apologies:	None	
In attendance:	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance
	Tom Jackson	Consultant Clinical Psychologist, Learning Disability Services (item 14)
	Karen Taylor	BDU Director, Calderdale, Kirklees and specialist services

CG/14/41 Welcome, introduction and apologies (agenda item 1)

The Chair (HW) welcomed everyone to the meeting. The Committee noted that Ian Black (IB), Chair of the Trust, is joining the Committee until December 2014 following Bernard Fee's departure.

CG/14/42 Minutes of the previous meetings held on 15 April and 13 May 2014 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meetings held on 15 April and 13 May 2014.

CG/14/43 Matters arising (agenda item 3)

There were four matters arising.

CG/12/34 Update on progress to devolve pharmacy services to BDUs

Nisreen Booya (NHB) confirmed that a Chief Pharmacist has been appointed. Jane Riley, currently at Leeds and York Partnership NHS Foundation Trust, will take up post in August or September 2014.

AC/14/13 Service users into employment (agenda item 3.1)

HW confirmed this would be included in the rehabilitation and recovery/IMRoC transformation work, which will come to the Committee in due course.

AC/14/25 Pressure ulcer incidents (agenda item 3.2)

Tim Breedon (TB) will present a wider report on tissue viability and how the Trust intends to provide the best service it can to patients to the next meeting.

Action: Tim Breedon

AC/14/37 Equality report (agenda item 3.3)

At April's Trust Board, it was agreed to prioritise ethnic minorities and communities by Business Delivery Unit (BDU) and locality. A joint piece of work has also been agreed with Calderdale and Huddersfield NHS Foundation Trust on Trust Board diversity led by HW.

CG/14/44 Committee annual report 2013/14 – review of areas raised under the self-assessment (agenda item 4)

HW took the Committee through the areas identified and the following action was agreed. This will be reviewed as part of the annual reporting exercise for 2014/15.

Action: Helen Wollaston/Bernie Cherriman-Sykes

1. Training
   This is a particular issue for new Non-Executive Directors and it was suggested that a focussed meeting is arranged with members of the Committee prior to a first formal meeting.
2. Identifying key risk areas
   The Committee now receives internal audit reports relevant to its terms of reference.
3. Integration with other Committees
   The Chair of the Trust was asked to bear this in mind when reviewing Committee membership and it was agreed that one Non-Executive Director sitting on both this Committee and the Audit Committee would be useful.

   Action: Ian Black
4. Performance management
   The Committee will discuss consideration of the Quality Performance Report to strengthen this link.
5. Quality of reports
   The structure of the agenda has been reviewed and revised by the incoming Chair. Clarity of what the Committee requires following agenda setting has also improved the quality of papers. Any further comments should be passed to HW or TB.
6. Management action arising from audit reports
   As appropriate, the Committee will agree completion and follow up dates to be clear on requirements.
7. Costs incurred by the Committee
   The Mental Health Act Committee suggested that this is an issue for all Trust Board Committees and that there should be a review across all Committee in terms of attendance, how often Committees meet and who attends. This would be taken forward by the Director of Corporate Development in her role as Company Secretary on behalf of the Chair of the Trust. The Committee supported this proposal.

   Action: Dawn Stephenson

CG/14/45 Impact of cost improvement programme on Trust services and quality impact assessment process and outcome for 2014/15 – shift patterns and mandatory training (agenda item 5)

Shift patterns

Alan Davis (AGD) explained the background and outcome of BDU reviews of in-patient shift patterns, which demonstrate that shift patterns and overlap periods are different across the Trust and across services. Information has been shared with staff side. TB reported that the initial Quality Impact Assessment (QIA) finding pre-mitigation is 'poor' (negative impact) and post-planned mitigation is 'neutral' (will not result in perceived reduction in the quality of services). A follow-up meeting reviewed the mitigating action in place and, although in the main satisfactory and providing some assurance, more information was requested on rotas to show what shifts would look like in practice. As a result, a two-month mock rota ward-by-ward will be assessed on 18 July 2014. At this point the final QIA rating can be concluded.

HW asked about the impact on staff working twelve-hour shifts. TB responded that evidence and feedback is mixed, and its introduction will be reviewed, particularly in terms of patient safety, quality of services and occupational health. AGD confirmed that the Trust has its own mechanisms to assess whether its staff work excessive hours; however, this Trust has no mechanism for staff who work for other organisations.

There will be an opportunity to look at different shift patterns in community services as community hubs develop and service models change during transformation to suit the needs of service users.
AGD confirmed that the cost saving is 'amber' currently and some areas will move to 'green' by the start of quarter 3.

Mandatory training
A further risk assessment of the proposal to reduce headroom for mandatory/statutory training will take place on 18 July 2014.

TB will present the final quality impact assessment against both cost savings to a future meeting.

Action: Tim Breedon

CG/14/46 Hard Truths, the Government's final response to the Francis Report – staffing level reviews and reporting (agenda item 6)

Staffing data
A paper was tabled. TB explained its background and took the Committee through the key points. Next steps were noted as:

- a review of planned against actual staffing level data on a monthly basis from June 2014;
- development of an evidence-based tool to review in-patient staffing levels, ensuring alignment with possible national guidance to be issued later this year by December 2014; and
- completion of an investigation into defined key lines of enquiry and action taken as required by September 2014.

TB will circulate the initial report as an example of what the Trust will publish.

Action: Tim Breedon

Julie Fox (JF) suggested benchmarking Trust figures against other, similar Trusts. Nisreen Booya (NHB) commented that the information was very useful and will also be useful for the Mental Health Act Committee. The Trust now needs to look further at the inconsistencies identified in the report and whether changes are needed in any areas.

TB confirmed that actual figures should be available in the next few days and will be benchmarked against establishment figures for Trust Board in June 2014. It was agreed that TB would convene a conference call to look at the figures in more detail involving HW, IB and, potentially, JF. It was also agreed it would be helpful for the Chief Executive to raise lack of guidance with the NHS Confederation.

Action: Tim Breedon

Francis staff workshops
NHB commented that leadership is a theme throughout the feedback at all levels and the new triumvirate arrangements in BDUs should address staff concerns.

TB explained the rationale for inviting staff to provide workshop feedback in the form of a 'mock' letter to Trust Board with their concerns and confirmed that a formal response will be made following a senior level review on 24 July 2014. This approach provides clear evidence of 'ward-to-board' linkages and the Trust's commitment to an open and transparent dialogue. HW was keen that the Trust responds to areas where it has taken action or where action is in train as well as addressing the long-term issues raised.

The Committee noted that, whilst the feedback was from a small percentage of staff, the messages are powerful and should be given serious attention and consideration. TB reminded the Committee of the substantial assurance rating given to the Trust's response to the Francis Report, its implementation process and approach to candour.

CG/14/47 Understanding the governance framework for medical practice (agenda item 7)

The paper was seen as helpful in understanding the processes in place. This will be supported by the annual report on revalidation presented to Trust Board in June 2014.

CG/14/48 Unannounced visits (agenda item 8)

Karen Holland (KH) reported that eight visits had taken place, four in community services and four in in-patient. Of these, two areas require improvement although not in directly in relation to patient safety. The visits received good feedback from Trust Board and from staff who participated. IB asked if the focus of the visits should move to the new style Care Quality Commission (CQC) review process to prepare Trust services. It was agreed this would be a good idea. KH confirmed that work has begun but there are still areas to review and address.

IB also asked whether any visits were rated 'excellent' or 'unacceptable', that is, at the top and bottom of the scale, or whether the Trust tends towards the middle ground. KH agreed to review the ratings and provide an assessment to the Committee.

Action: Karen Holland

The Committee noted that AGD has planned visits to each in-patient until with members of the estates team over the next few months to raise estates' profile and ensure environmental issues are identified and addressed swiftly and effectively.

The Mental Health Act Committee receives information on estate and clinical issues raised by the CQC and it was suggested it would be more appropriate for this Committee to receive the report.

Action: Tim Breedon

CG/14/49 Implementation of the actions arising from the medicines management internal audit (agenda item 9)

The report was noted by the Committee. The Trust is required to appoint a Medicines Safety Officer in addition to the Accountable Officer for controlled drugs, which will be confirmed when the Chief Pharmacist joins the Trust. The Committee also noted that a self-assessment against a national audit tool for security of medicines had been undertaken and an action plan developed.

The Committee asked that assurance checks continue on a monthly basis.

CG/14/50 Internal audit reports (agenda item 10)

Serious incidents (agenda item 10.1)

The report, which provided substantial assurance, was noted. The report confirms the positive steps taken around the Trust's incident management systems.

CG/14/51 Annual reports (agenda item 11)

Research and development (agenda item 11.1)
The report was noted.

CG/14/52 Sub-groups (agenda item 12)

Incident Review Panel
The independent review of homicides continues. Interviews are complete and a report is awaited.

Drugs and therapeutics
No issues to raise.

Health and safety
No issues to raise.

Infection Prevention and Control
The report was noted.

Safeguarding
The Committee noted that OfSTED is currently visiting services in Barnsley

Managing aggression and violence
No issues to raise.

CG/14/53 Children's services (agenda item 13)

Karen Taylor (KT) updated the Committee on progress against the recovery plan. She anticipates a nine-month period for recovery at an estimated cost of £330,000. A bid for non-recurrent funds has been submitted to commissioners and is currently being funded by the Trust.

NHB clarified the issue regarding Autism Spectrum Disorder (ASD) and children waiting for assessment. The issue is not solely for the CAMHS to address; the solution also relies on education and social services. This also needs to be clarified with commissioners to manage expectations and potentially using the model currently in place in Wakefield, which is working well.

KT confirmed that the Trust is very much taking a lead role in developing an holistic service for CAMHS across health, social care and education. The implementation of triumvirate management arrangements will support robust implementation of the recovery plan with a consistent approach across the Trust with the appointment of one clinical lead.

It was agreed to keep this matter on the Committee's agenda and suggested that it should be part of the Trust Board performance dashboard in the form of measurable performance indicators for waiting times, and patient and stakeholders' experience. KT estimated a period of two years before the Trust could have a service it can be proud of. The Committee, therefore, recommended continued reporting to Trust Board until the end of 2014/15 as well as to the Committee and for a further financial year to the Committee.

Action: Karen Taylor

CG/14/54 Transformation programme – learning disability services (agenda item 14)

Presentation from Tom Jackson, clinical lead for transformation of learning disability services. The presentation received positive comments from all present, particularly noting the clarity of the plan and service offer.

CG/14/55 Quality Accounts 2013/14 and update on plan for 2014/15 (agenda item 15)

TB updated on the following.

- The seven-day follow up issue was resolved and the Quality Accounts were not qualified as a result.
- The Trust received more feedback from stakeholders that previous years and will respond to the comments made.
- The review by Deloitte was positive on the process and content.

He thanked Karen Batty for her efforts in producing the report.

IB commented that it seems that clinical commissioning groups want more on their own districts. TB responded that the Quality Accounts is a Trust-wide report and contracting and quality boards consider district-wide issues in more detail.

CG/14/56 Quality reporting to Trust Board (agenda item 16)

To be discussed at a later date.

CG/14/57 Date of next meeting (agenda item 17)

The next meeting will be held on Tuesday 9 September 2014 at 14:00 in the Langsett room, Kendray Hospital, Barnsley.

Minutes of the Mental Health Act Committee Meeting held on 13 May 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
	Dawn Stephenson	Director of Corporate Development
In attendance:	Derek Boothby	Mental Capacity Act Professional Lead (Wakefield) – local authority representative
	Julie Carr	Mental Health Act/Mental Capacity Act Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Stephen Evans	Solicitor, Hempsons (item 2)
	Yvonne French	Assistant Director, Legal Services
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	David Longstaffe	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**	
	None	
	Attendees	
	Kyra Ayre	Acting Head of Service, Mental Health and Assessment and Care Management (Barnsley) – local authority representative
	Antonis Lakidis	Associate Specialist, Calderdale

MHAC/14/13 Welcome, introduction and apologies (agenda item 1)

Julie Fox (JF) welcomed everyone to the meeting. The apologies, as above, were noted.

MHAC/14/14 The Act in practice – Compliance and Assurance Pathway presentation – capacity and consent (agenda item 2)

Stephen Evans, Hempsons, presented on capacity and consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and, in particular, the judgement of the Supreme Court in relation to P and Q vs. Surrey County Council.

The implication for the Trust of this ruling is that there is no longer an option for an informal patient to lack capacity. The ruling also has implications for capacity within local authorities as DoLS have increased as a result. Trust action is now required to review all relevant patients and either consider use of the Mental Health Act or apply to the relevant local authority for DoLS pending further clarification of the process.

Tim Breedon (TB) was asked to develop a Trust response for the Committee to consider, which should include the wider health and social care economy perspective, a plan for awareness raising and engagement with clinicians and local authorities, and any resource issues for the next meeting. However, the Committee asked that, if a critical issue arises in the meantime, it should go directly to Trust Board.

Action: Tim Breedon

MHAC/14/15 Legal update/horizon scanning (agenda item 3)

Department of Health Deprivation of Liberty Safeguards guidance
This was considered under item 2 above and the following points also considered.

- The guidance also applies to general community services.
- It will lead to an increase in formal detentions and applications under DoLS.
- It will result in a significant increase in day-to-day activity, such as Hospital Managers' hearings.

The Committee asked that a capacity assessment is undertaken at the beginning of the process and that these are recorded, that there is a consistent approach across the Trust, and that there is a plan for service user and carer engagement and communication.

Action: Tim Breedon/Dawn Stephenson/Yvonne French

Deprivation of Liberty Safeguards, Hempsons
This was considered under item 2 above.

Independent Police Complaints Commission investigation into the death of Sean Rigg
Welfare checks rather than Mental Health Act checks
A&E doctor failure to ensure assessment of mental health patient – see also matters arising below.
Senior President of the Tribunal – extract from report
All cases were noted and the implications for the Trust explained and noted.

MHAC/14/16 Minutes from the previous meeting held on 25 February 2014 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 25 February 2014.

MHAC/14/17 Matters arising from previous meeting (agenda item 5)

There were five matters arising.

MHAC/13/13 Yorkshire Ambulance Service
MHAC/13/29 and 34 Assess implications for S136 suites of Department of Health Mental Health Crisis Concordat
MHAC/1313/29 Review admissions to S136 suites for under 18s
These items were taken together.

TB reported on a positive meeting in Kirklees with Jed McManus, Superintendent at West Yorkshire Police in relation to:

- conveyancing;
- use of S136 suites;
- Yorkshire Ambulance Services; and
- liaison services.

A structured piece of work will be undertaken around development of a model across West Yorkshire and, as part of this, to establish a forum to deal with connectivity, which will include links with the Ambulance Service, initially in Kirklees with the intention to extend to all of West Yorkshire. A summary will come back to the next meeting.

Action: Tim Breedon

In relation to use of S136 suites for under 18s, TB reported that there have been 25 incidents of admission to the Trust's 136 suite services during 2013/14. The Committee asked that this continues to be monitored as there is a perception that this number is increasing.

Action: Tim Breedon

It was suggested that the Committee invites West and South Yorkshire Police, the Probation Service and Multi-Agency Public Protection Arrangements (MAPPA) to the November meeting to make a joint presentation on links and how the organisations work together.

Action: Tim Breedon

MHAC/14/07 Review of cancelled S17 leave due to low staffing levels
The Committee noted there was no further information on this.

MHAC/14/09 Update on Approved Mental Health Practitioners (AMHP) position in Barnsley and Kirklees
See item 10.

MHAC/14/18 Mental Health Act Committee annual report – follow up of issues arising from the Committee self-assessment (agenda item 6)

The Committee considered the issues raised in the Committee self-assessment and agreed a number of actions.

Has the Committee formally considered how it integrates with other Committees, particularly the Audit Committee, that are reviewing risk?
This was considered to be sufficient with clear links between each Committee in terms of Non-Executive Director membership of Committees and through the Director of Corporate Development.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?
It was agreed that it would be useful to map how Mental Health Act data maps across to the quality performance report at the next meeting.

Action: Tim Breedon

Has the Committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly in regard to the Statement on Internal Control, CQC Registration and Regulation, NHS LARMS and other areas of compliance, particularly that of clinical risk?
It was agreed that it would be useful to receive a paper on this and Dawn Stephenson (DS) was asked to draft a brief narrative to incorporate into the above report from TB.

Action: Dawn Stephenson

Has the Committee considered the costs that it incurs and are the costs appropriate to the perceived risks and benefits?
This applies to all Committees and it was agreed to review in terms of attendance, how often Committees meet and who attends.

Action: Dawn Stephenson

Is the timing of Committee meetings discussed with all parties involved?
The Committee agreed quarterly meetings were adequate and the timing appropriate.
Does the Committee assess its own effectiveness periodically?
It was agreed that the current approach is appropriate.

Any further ideas should be passed to JF or TB.

Action: ALL to note

MHAC/14/19 Audit and Compliance Reports (agenda item 7)

Consent to Treatment audit

Four recommendations were made in relation to continued improvement:

- to review the process for scrutiny of documentation in Calderdale;
- to progress the RiO paper-light Mental Health Act file;
- to build on the improvement shown in the recording of capacity to consent to treatment; and
- to improve recording by statutory consultees.

The Committee asked for a re-audit to take place to evaluate the outcome of the action taken to report into November's meeting. The Committee also expressed a concern at the lack of assurance provided by the audit, particularly given the issues raised earlier in the meeting. The Committee was also keen that areas where there are recurring issues are addressed at local level. Each Business Delivery Unit (BDU) will be asked to provide information for the next meeting on how these issues have been addressed.

Action: Yvonne French

Care Quality Commission annual reports – Mental Health and Mental Capacity Acts

It was agreed to set a metric for Mental Health Act training as part of the review of mandatory and core training. The Committee thought it would be useful to receive information currently held on the Electronic Staff Record system.

Action: Tim Breedon

The Committee asked for the action plan to include a status column. When an action is completed and has been to the Committee, it can be taken off the report.

Action: Yvonne French

In relation to issue 14 ("CCG – legal duty to identify in-patient unit where patients can be admitted in 'cases of special urgency' and inform local authorities), TB agreed to raise with commissioners through contracting discussions and provide an update to the next meeting.

Action: Tim Breedon

MHAC/14/20 Care Quality Commission Visits (agenda item 8)

Recent visits

The five monitoring visits to Appleton ward, Newton Lodge (30 January 2014), Elmdale ward, The Dales, Halifax (13 February 2014), Horizon Centre, Fieldhead, Wakefield (10 January 2014), 8 Fox View, Dewsbury (30 January 2014) and Hepworth/Gaskell ward, Newton Lodge (13 March 2014) were noted. Although the reports were positive, particularly for Fox View, Dewsbury, there were a number of recurring themes in relation to:

- health care plans;
- patients' rights;
- S17 leave;
- care plans; and
- assessment of capacity.

Helen Wollaston (HW) expressed a concern that another estates issue had not been resolved in a timely way and followed up.

S136 place of safety audit

The Committee noted that the full report would be published in the summer.

Outstanding actions/progress report
In relation to the Estates TAG report on the environment, HW suggested that an annual report should also be presented to the Clinical Governance and Clinical Safety Committee on issues arising from CQC Mental Health Act visits for assurance on compliance.

The clinical report was noted.

MHAC/14/21 Monitoring Information (agenda item 9)

A paper was tabled providing an illustrative representation of the statistics. Any comments on the presentation should be passed to TB or Yvonne French (YF) by the end of May 2014.

Action: ALL to note

The next phase will develop a more in-depth analysis of the statistics. TB and YF also agreed to look at relevant and appropriate comparators.

Action: Tim Breedon/Yvonne French

No issues were raised on the monitoring information.

Local authority information
Calderdale – Ian Priddey (IP) reported a continued shortage of AMHPs in Calderdale. Interviews have been held for 1.9 posts; however, there have been limited applicants. There has also been an increase in the training of AMHPs and provisional agreement has been given to fund training for three AMHPs in 2014/15.

Kirklees – there are 33 AMHPs in post and nine more would be the optimum number. Funding has been confirmed for sixteen potential social workers to be trained over the next three years with six in October and four in January 2015; however, this also needs to cover AMHPs coming up for retirement.

Barnsley – there are twenty in total but this is insufficient to meet demand. Although there are four AMHPs in training, release of staff for training and funding remain as issues.

Wakefield – the Council is in a good position currently; however, there is a debate internally on whether there is any requirement to train AMHPs.

Hospital Managers' Forum
The Forum notes from 3 April 2014 were received and noted.

MHAC/14/22 Matters Arising (agenda item 10)

Local authority representation
The Committee appreciates attendance by local authority representatives and was happy that representation had been agreed for future meetings.

Hospital Managers' financial annual review
The Committee agreed that JF and TB would formally agree the 1% uplift when the advice from finance has been given and any award would be backdated to 1 April 2014. This will be confirmed at the next meeting.

Action: Julie Fox/Tim Breedon

JF also asked the Committee for its view on inviting a representative from acute trusts to meetings in future. It was agreed that TB would approach the three acute trusts and agree appropriate representation.

Action: Tim Breedon

MHAC/14/23 Key messages for Trust Board (agenda item 11)

The key issues to report to Trust Board arise from the presentation from Stephen Evans and feedback from the consent to treatment audit.

MHAC/14/24 Date of next meeting

The next meeting will be held on Tuesday 5 August 2014 from 14:00 to 16:30 in training room 3, Learning and Development Centre, Fieldhead, Wakefield.

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 1 April 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:	Peter Aspinall	Non-Executive Director
	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/14/13 Welcome, introduction and apologies (agenda item 1)

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

RTSC/14/14 Minutes of the previous meeting held on 4 February 2014 (agenda item 2)

It was RESOLVED to APPROVE the minutes from the meeting held on 4 February 2014

RTSC/14/15 Matters arising from previous meeting (agenda item 3)

RTSC/13/56 Medical staff performance

Helen Wollaston (HW), as Chair of the Clinical Governance and Clinical Safety Committee, will commission a paper, through that 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/14/11 Director appraisals

Non-Executive Director comments were invited as part of the Directors' appraisal process. Steven Michael (SM) agreed to re-circulate the proforma for Non-Executive Directors to complete.

Action: Steven Michael

RTSC/14/16 Human resources exception report (agenda item 4)

Turnover rate

Jonathan Jones (JJ) commented that the 8.6% turnover rate supports the general feeling at Trust Board that the Trust is not taking a sufficiently challenging approach to its staffing levels and reducing its workforce. IB asked that, at the next meeting, the Committee looks back at an analysis of 2013/14 turnover figures. Alan Davis (AGD) commented that it would also be timely to review the target range and whether the 5 to 10% is still relevant.

Action: Alan Davis

SM also asked that the staffing structure chart by grade (the 'Christmas tree') is updated against the whole-time equivalent headcount and in terms of the workforce plan, and benchmarked against other Trusts. AGD added that there is also a benchmarking exercise for management and administration costs, both within BDUs and support services, supported by KPMG.

Action: Alan Davis

Suspensions

JJ asked for clarification of the suspensions of staff table. AGD provided an explanation and confirmed that the Trust will monitor the position over the next twelve months and seek to resolve suspensions in a timely way, which has not always been the approach up to now. Any suspensions over 30 days allowed in the policy will need his approval as Director of Human Resources to continue. The Committee also asked for an analysis of the 2013/14 suspensions at the next Committee.

Action: Alan Davis

Sickness absence

The key area of focus for 2014/15 will be areas of the Trust performing better than the 4% target and how these areas can learn from others that have achieved 4%.

The Committee commented that it would find operational commentary by BDU Directors on some performance-related issues useful. It was agreed to identify a workforce/HR topic to review in detail at each meeting, which would include a level of operational detail, starting with suspensions in July 2014. Workplace bullying was also identified as another area for July and staff surveys at the meeting in October 2014.

Action: Alan Davis

AGD also took the Committee through the highlights from the national staff survey and wellbeing survey results, particularly those area where this Trust was at a significant variance from the national norm.

RTSC/14/17 External review of Directors' remuneration (agenda item 5)

AGD took the Committee through the report. He reminded the Committee that stage 1 looks at the remuneration of voting Directors only.

Alan Davis left the meeting at this point.

It was RESOLVED to APPROVE the Chief Executive's proposal in relation to the remuneration of the Deputy Chief Executive/Director of Finance, Director of Human Resources and Workforce Development, and the Director of Nursing, Clinical Governance and Safety.

Steven Michael left the meeting at this point.

The Committee agreed to the Chair's proposal that a review is undertaken of the Chief Executive's pay band and his position on it after the end of the 2014/15 financial year.

Steven Michael and Alan Davis re-joined the meeting at this point.

The Committee agreed that the Capita report was constructive and helpful, particular when compared with previous reports.

RTSC/14/18 Directors' performance related pay update (agenda item 6)

SM confirmed that two out of the three gateway objectives had been achieved in relation to the financial risk rating and compliance. The gateway target in relation to transformation had not been achieved as explained by SM at the previous Committee meeting. Therefore, a corporate award of 2% will be paid. This also reduces the control payment to 4.5% of the total Directors' paybill. SM will make an assessment of individual awards following his quarter 4 reviews with Director; however, quarter 3 reviews show a degree of variation in

performance and a proposal will come to the Committee in July 2014. The Committee confirmed the previous agreement that any award under the scheme is not pensionable.

Action: Steven Michael

IB also asked for a proposal for the 2014/15 scheme at the same meeting. The Committee agreed it should be consistent with previous years and should reflect 2013/14 with further consideration of individual components. This would be on the basis of consistency and that the approach remains to reward both stretching corporate and personal objectives.

Action: Alan Davis

RTSC/14/19 Workforce CIP/QIPP (agenda item 7)

It was agreed to review at Trust Board as part of the discussion in relation to achievement of the two-year operational plan.

RTSC/14/20 Update on leadership and management structure (agenda item 8)

SM updated the Committee on progress.

Leadership and management structures

SM confirmed that:

- BDU Deputy Directors are now in post;
- the next stage is to confirm the clinical lead/general management/practice governance arrangements for each BDU and ensure fit with service line management;
- Deputy Directors are in place for support directorates with the exception of the Nursing Directorate, which has been re-advertised, and the Head of Leadership and Management Development (interviews will be held following an external recruitment exercise), which will enable AGD to confirm his deputy arrangements.

In relation to succession planning and identification and promotion of talent, AGD outlined two strands.

- The Talent Pool provides opportunities for individual members of staff at all levels to develop by leading or being involved in Trust activity and initiatives outside of their usual role or type of work.
- The talent pipeline will identify key roles in the organisation and look at how these could be filled if needed. A paper on this will come to the Committee in July 2014.

Action: Alan Davis

RTSC/14/21 Medical staffing: leadership and management remuneration (agenda item 9)

Covered under agenda item 8.

RTSC/14/22 Revision of the appraisal policy and target (agenda item 10)

AGD advised that the revised appraisal policy had been approved by the Executive Management Team (EMT). EMT also agreed that bands 6 and above would be required to complete their appraisals by the end of June 2014 and remaining staff by the end of September 2014. Both targets would increase to 95%.

RTSC/14/23 Any other business (agenda item 11)

Directors' performance related pay

It was agreed to convene a meeting in May 2014 with two items for the agenda:

- Directors' performance related pay; and
- Medical Director appointment.

It was agreed that Non-Executive Directors could join the meeting by phone if needed.

Action: Alan Davis

RTSC/14/24 Date of next meeting (agenda item 12)

The next meeting will be held on Tuesday 15 July 2014 at 14:00 in the Chair's office, block 7, Fieldhead, Wakefield.

Minutes of Audit Committee held on 8 April 2014

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
Apologies:	Members	
	Jonathan Jones	Non-Executive Director
	Others	
	Dawn Stephenson	Director of Corporate Development
	Paul Thomson	Partner, Deloitte
In attendance:	Ian Black	Chair of the Trust
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety (to item 5)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Tony Cooper	Head of Procurement
	Mark Dalton	Manager, KPMG
	Alex Farrell	Deputy Chief Executive/Director of Finance (from item 5)
	Paul Hewitson	Senior Audit Manager, Deloitte
	Debbie Hogg	Deputy Director of Finance
	Clare Partridge	Director, KPMG (Head of Internal Audit)
	Karen Sharrocks	Senior Manager/LCFS, KPMG
	Michael Smith	Publicly elected Governor, Calderdale
	Robert Toole	Interim finance support

AC/14/21 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/14/22 Minutes of the meeting held on 21 January 2014 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 21 January 2014 as a true and accurate record of the meeting.

AC/14/23 Matters arising from the meeting held on 21 January 2014 (agenda item 3)

There were three matters arising.

AC/13/52 Audit Committee self-assessment – training (agenda item 3.1)

PA has asked Deloitte and KPMG to develop a proposal to discuss with the Chair for a training 'programme' starting in July 2014.

Action: Deloitte/KPMG

PA will circulate the healthcare session presentations from the KPMG Audit Committee Institute when received as this provides good background for Committee members.

Action: Peter Aspinall

AC/14/04 Itemised payments made to staff through payroll (agenda item 3.2)

Payroll has confirmed that, other than normal travel expenses, the only ad-hoc payments made to medical staff are for Mental Health Act Assessments and locum payments. Payroll checks to ensure that these are authorised appropriately before making payment. Nisreen Booya (NHB) commented that Mental Health Act assessments attract a fee; however, there

are different arrangements in each BDU. The Trust is working with commissioners to standardise the system for payment across the Trust and a standard form for use by local authorities to authorise an assessment will also be developed to ensure all payments are made through the Trust. NHB also understood that there were other ad-hoc payments made to staff, in particular, medical staff. As a result, the Committee asked for a further response from the Director of Human Resources given the Medical Director's comments.

Action: Alan Davis

AC/14/06 Advice and support provided to the Trust by Deloitte on strategic and tactical IT procurement (agenda item 3.3)

Alex Farrell (AF) confirmed that Deloitte was commissioned by the Trust to provide commercial advice and guidance in relation to the Trust's IT procurement. The initial brief was to support the Trust to review and provide comment on the work that the Trust's procurement team undertook, undertake schedule drafting where required on behalf of the Trust on the proposed changes in conjunction with external legal advisors and to support the Trust during bidder dialogue to execute the changes made. From this initial brief, Deloitte provided support to define and document a number of commercial principles, and facilitated and challenged suppliers during the commercial dialogue sessions, working closely with the Trust's legal advisors in the definition and documentation of the commercial principles. Following the commercial dialogue session, Deloitte was also commissioned to provide the Trust with financial modelling and VAT liaison advice. AF and Deloitte confirmed that there had been a separation of duties for the work undertaken.

Bernard Fee (BF) asked how the Trust would judge value from the exercise. Robert Toole (RT) responded that Deloitte had managed the whole process of commercial terms in addition to its advisory role. It, therefore, offered good value for the Trust in terms of understanding the terms of contracts and risk mitigation.

The Committee was assured by the response given.

AC/14/24 Audit Committee annual report to Trust Board 2013/14 (agenda item 4)

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

Audit Committee

Chair – Peter Aspinall; Lead Director – Alex Farrell

The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation. Any action required as a result of the self-assessment will be reviewed by the Committee in July 2014. A proposal from the Chair in relation to Committee training will be taken forward by Deloitte and KPMG.

It was agreed to amend the terms of reference under counter fraud to refer to NHS Protect.

Clinical Governance and Clinical Safety Committee

Chair – Helen Wollaston; Lead Director – Tim Breedon

The Committee met its Terms of Reference and continued to develop its work programme throughout the year to reflect the risks and objectives of the organisation. A revised format covering four specific areas (standing items, assurance, key clinical risks and quality improvement) will be introduced for 2014/15. This reflects the wide scope of work within the Committee's remit and the need to balance scrutiny of improvement activity and monitoring of risk. There has been good attendance at the Committee throughout the year and, from April 2014, BDU Directors will be invited to attend to provide an operational perspective to issues on the Committee's agenda. The Quality Impact Assessment arrangements have been a key area for Committee scrutiny and monitoring throughout the year to provide assurance on the process and the impact on Trust services.

Mental Health Act Committee

Chair – Julie Fox; Lead Director – Tim Breedon

The Committee fulfilled its Terms of Reference and met its work programme over the year. TB drew the Committee's attention to the following areas.

- Following feedback from the Hospital Managers' reviews, the Hospital Managers' Forum has been strengthened during the year and its role, remit and representation on the Committee clarified.
- The Committee commissioned and received reports on the outcome of Section 17 and Section 132 audits. Action in relation to both is monitored through the Committee.
- Clinically-led presentations at the start of each meeting bring the Mental Health Act to life for the Committee through clinicians explaining how the Act works in practice.
- There has been significant improvement in the way the Trust implements actions arising from Care Quality Commission Mental Health Act visits as a result of the Committee's challenge and scrutiny.
- Further work will be undertaken in 2014/15 on interpretation and analysis of data to build on progress during the year.

Remuneration and Terms of Service Committee

Chair – Ian Black; Lead Director – Alan Davis

The Committee met its terms of reference and fulfilled its work programme for the year. The programme is reviewed regularly by the Chair of the Committee to ensure it reflects the risks and objectives of the organisation and that the Committee adds value. IB commented on the sabbatical taken by one member of the Committee. Although the Committee did meet during this time, the meeting was quorate and the Non-Executive Director concerned was given the opportunity to provide comments on the items considered at the meeting.

In relation to training for members of this Committee, IB felt that there was no requirement for current members; however, this would change should the membership of the Committee change. He also commented that papers were now circulated in a timely way.

RT asked about the Committee's role in consideration of the mutually agreed resignation scheme (MARS). IB confirmed that the Committee considers applications from Bands 8A and above and the Director of Human Resources provides a summary report on applications from staff up to Band 7. KPMG was asked to advise whether this is seen as appropriate.

Action: KPMG

PA asked that all Committees review the outcomes of their self-assessments at some point in the coming year and it was agreed that these would be scheduled into forthcoming agendas.

Action: Chairs of Committees

Summary

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

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

As a result, **it was RESOLVED to APPROVE the second draft of the Audit Committee annual report to Trust Board**.

AC/14/25 Service line reporting and currency development (agenda item 5)

RT explained this was an update report on the current position. The project continues to make good progress and the focus is now on communication and ensuring service line management is embedded in performance management arrangements. AF added that service line reporting is incorporated into transformation. There will also be a baseline assessment in each community mental health team and the quality of clustering will form a key part of this work. She also commented that there is good partnership working with commissioners and reiterated the comment from RT that service line reporting should be embedded in good clinical practice as opposed to being a financial tool. There are some improvements to be made but there has been good progress so far, particularly in relation to the experience of other trusts.

BF commented that this was a good piece of work undertaken to really understand the Trust's business and he would not want to see this lost if national policy changes. AF was of the view that the Trust will continue to use this methodology as there is no real alternative and it provides a good framework for the Trust.

IB asked if the Committee considers risks associated with the arrangements. AF responded that there are two main issues:

- to manage the expectation of commissioners around performance with penalties introduced from 1 April 2014 (paper to Trust Board in April 2014);
- to ensure service line reporting is used to support clinical transformation and clinical performance, and that the Trust can evidence it is making a difference in terms of outcomes.

AF felt there were still a number of negotiations and opportunities for the Trust to influence the national outcome before a final decision is made. BF added that it will still ensure the Trust understands its cost base whether tariff goes ahead nationally or not.

PA commented that the role of the Committee was to receive assurance that the Trust has systems and processes in place to develop and implement service line reporting and currency development. AF suggested that BDU Directors are invited to the next meeting to explain how they use and apply service line reporting.

Action: Alex Farrell

AC/14/26 Triangulation of risk, performance and governance (agenda item 6)

PA commented on the fact that, as a number of risks are long-standing, what assurance did the Committee have that mitigating action in place is both timely and effective. AF felt that the responses in the risk register were appropriate and progress is made, which is reflected in the updated narrative.

BF asked whether, following the discussion at Trust Board in March 2014, the two-year operational plan should be included on the risk register. NHB agreed that it should be and AF agreed to take this back to the Executive Management Team (EMT).

Action: Alex Farrell

IB commented that financial challenges are faced by other Trusts and there will be difficulties faced by partners to deliver their operational plans. He suggested explicit reference to the current difficulties faced, particularly by Mid-Yorkshire Hospitals NHS Trust and Barnsley Hospital NHS Foundation Trust, on the risk register and it was agreed to discuss this more fully at Trust Board in April 2014.

AF commented that the Better Care Fund may also provide a risk to the Trust. Provider engagement has not been ideal and the detail of delivery and implementation will become increasingly important. The Trust needs to ensure parity of esteem and that it is part of the development and delivery of integrated services. BF commented that financial management will become increasingly important as NHS Trusts are more financially challenged and the Trust needs to be able to address and react to local issues.

AC/14/27 Treasury management update (agenda item 7)

IB asked why the Trust invests with the Government Banking System (GBS) at 0.25% interest when it could attract 0.6% with two Government-backed commercial organisations. AF responded that there had been changes to the GBS arrangements where, if Trusts invest outside, they will pay more public dividend capital and, therefore, the Trust would need a higher rate of 3.5% to make up the difference.

AC/14/28 Internal audit progress report (agenda item 8)

Clare Partridge (CP) introduced this item. The work by KPMG on core operations during the year provided a substantial assurance opinion, which means a substantial assurance opinion can be made by the Head of Internal Audit for the year ending 31 March 2014. Mark Dalton (MD) took the Committee through the suite or reports.

Progress report

Eight reports were complete and presented to the Committee.

- Information Governance Toolkit (follow up) – substantial assurance
- Financial management and reporting, including procurement (non-pay purchasing) follow up – substantial assurance
- Monitor provider licence – substantial assurance
- The Trust's response to Francis II – substantial assurance
- Transformation, including service line reporting – moderate assurance
- Data quality – moderate assurance
- Leadership development – moderate assurance
- Significant and serious incidents – substantial assurance

MD went on to highlight the key findings from the three moderate assurance audits. BF asked whether moderate would become limited assurance if reviewed again with no progress. MD responded that the 2014/15 audit plan will look at progress and delivery and it was a fair assessment to make that a review would currently provide limited assurance. In 2013/14, the focus has been on the systems, policies and procedures in place and this will change in the coming year to focus on delivery, implementation and embedding.

PA commented that data quality continues to be an issue and the report highlights the Trust's slow response. He asked whether it would continue year-on-year. AF responded that the focus is on good clinical practice not a 'tick in the box' on RiO. There are also leadership and management issues and inconsistencies across BDUs, which BDU Directors are addressing. BF took assurance from KPMG's approach in 2014/15, which will provide evidence of how the Trust is using its systems to ensure good clinical practice. AF assured the Committee that the Trust is meeting the minimum requirements of its regulator. CP commented that it is likely to remain an issue as data and reporting become more and more important and, therefore, it is likely to remain as a key issue for the Trust.

Financial management

MD moved on to the financial management audit, which included a review/follow up of the recommendations from the procurement (non-pay purchasing) audit that provided a no assurance opinion. The follow up found that:

- there had been timely and effective progress in relation to the action agreed with management;
- the interim arrangements where permanent solutions have not yet been implemented were effective; and
- there was no indication of breaches in control during the period.

KPMG also evaluated the risk of financial loss for the period where control weaknesses were identified and found that there was no indication of financial loss.

Michael Smith (MS) asked whether the cultural operational issues had also now been resolved. AF responded that this related to ownership of solutions-focused responses, and responsibility and understanding of these responsibilities in the implementation of Trust systems and processes. PA asked if the Trust was now content that the professionally qualified financial staff are behaving within the standards expected by their appropriate Institutes. RT confirmed positively and commented that the review and questioning of spend by budget holders also ensure managers review and challenge expenditure.

Transformation

PA commented that transformation and the cost improvement programme appear to be synonymous. AF concurred and responded that the 2015/16 plan will not be achieved without transformation.

BF asked whether Trust Board should adopt a more formal approach to transformation in a similar way to estates and the IM&T Strategy. AF responded that transformation workstreams are currently at different stages of the 'discovery' phase moving towards implementation. Each workstream will move through a 'gateway' prior to implementation and she suggested that Non-Executive Directors could be involved at this point.

CP commented that, in her view and in comparison with other Trusts, the Trust is establishing robust processes but does now need to move forward. AF responded that most recommendations in the report have an April 2014 completion date and action is in train to meet the timescales. The findings have not come as a surprise and none of the recommendations were high priority but reflect areas where the Trust needs to move forward.

The Recommendation Tracker Report and technical update were noted.

Internal audit annual plan 2014/15
PA asked whether there was anything arising from the KPMG Audit Committee Institute that should be on the plan or is increasing in importance and it was agreed to consider the impact of partners on the Trust, data quality and kite marking during the year. AF commented that the work KPMG does with other organisations might be pertinent to the Trust and she would like KPMG to advise on appropriate areas.

It was RESOLVED to APPROVE the internal audit annual plan for 2014/15.

Internal audit protocols
MD commented that the protocols were discussed with the Director of Finance, the EMT and Extended EMT with the aim of working to realise the audit plan and individual reviews. Achievement will depend on clear and full scoping for audit activity, agreed in a timely way with the Trust.

AC/14/29 Counter fraud progress report (agenda item 9)

Progress report
Karen Sharrocks (KS) took the Committee through the update report.

PA asked whether the Trust and/or Audit Committee would be notified prior to any adverse publicity. KS responded that referrals are reported immediately to AF and, if it was anything of significant importance, to the Chair of the Audit Committee. Any issue that would attract media attention would be discussed with the communications team.

IB commented that there were not many whistleblowing incidents in this Trust and asked whether there should be an exercise to test staff awareness. AF responded that the Trust undertakes routine staff surveys and could include specific questions on whistleblowing. She agreed to talk to Alan Davis.

Action: Alex Farrell

KS added that there are a number of questions in the fraud awareness survey on reporting concerns and the whistleblowing policy is reviewed when the fraud and corruption policy is reviewed to ensure commonality. She felt that it seemed to be well embedded in this Trust.

Counter fraud annual plan 2014/15
RT asked if the plan would address the issues raised by NHS Protect in its assessment. KS responded that it does and also commented that NHS Protect will take a more reasonable approach to assessments in 2014/15. She will bring a review and report to the next meeting on the implications of this.

Action: Karen Sharrocks

It was RESOLVED to APPROVE the counter fraud annual plan for 2014/15.

AC/14/30 External audit update (agenda item 10)

Performance against the key performance indicators was noted and supported by the Committee.

The Committee also noted the response on the IT tender query, the financial performance report and the sector developments report. The report 'Better care for frail older people –

working differently to improve care' was circulated to the Committee. Deloitte is intending to organise workshops/seminars with the authors.

In relation to the comparison of financial performance, BF commented that, although the cost improvement programme comparison was useful, there was no judgement on the quality of the savings achieved. AF was also asked to look at the make-up of the Trust's cost improvement programme compared to other Trusts.

Action: Alex Farrell

Both Deloitte and KPMG will benchmark the annual plans submitted to Monitor of their client trusts and this will be shared with the Committee in July 2014. The Committee felt it would be useful to see the analysis; however, it will be difficult to assess how deliverable they are or whether they are intended to satisfy Monitor.

Action: Deloitte/KPMG

AC/14/31 Procurement report (agenda item 11)

Tony Cooper (TC) took the Committee through the report. He highlighted an area of non-compliance in relation to a sum of money spent with Anglia DNA for £12,491 by the Drug and Substance Misuse Service in Calderdale. The matter has been raised with the BDU Director and is subject to an HR investigation, which may result in disciplinary action. This demonstrates that the Trust's systems and processes can pick up areas where policies are not followed and action taken as result, providing assurance to the Committee.

There will be a further update to Trust Board on the position with the medical locums contract. NHB confirmed she is now assured about the preferred supplier's arrangements following her concerns raised at Trust Board in March 2014.

Action: Alex Farrell

The Committee noted the proposal to remain with the North of England Commercial Procurement Collaborative for a further year pending further development of the relationship with Shared Business Services.

It was agreed to receive the revised Procurement Strategy at the meeting in July 2014, which will incorporate 'Better Procurement, Better Value, Better Care – a procurement development programme for the NHS'.

Action: Tony Cooper

TC confirmed that Norfolk and Suffolk NHS Foundation Trust supplies a bespoke lithium monitoring service to the Trust, which is not available from any other supplier.

PA questioned tender/quotation waivers where time or urgency is still used as a reason. AF responded that the point was well made and she will take back to EMT, particularly in terms of maintenance and the need for more rigour around planning of work.

Action: Alex Farrell

AC/14/32 Losses and special payments report (agenda item 12)

The report was noted.

AC/14/33 Date of next meeting (agenda item 13)

The next meeting will be held on Tuesday 8 July 2014 at 14:00 in the Robin Norbury room, Kendray Hospital, Doncaster Road, Barnsley. The Audit Committee meeting to approve the

annual report, annual accounts and Quality Accounts will be held on Friday 23 May 2014 at 10:00 in training room 1, Learning and Development Centre, Fieldhead, Wakefield. There will be a pre-meeting for the Chair and Non-Executive Directors with Deloitte at 9:30.

AC/14/34 Any other business (agenda item 14)

IB asked the Committee to note the current position at Barnsley Hospital NHS Foundation Trust. This will form a formal agenda item at Trust Board in April 2014.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Audit Committee held on 23 May 2014

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
	Jonathan Jones	Non-Executive Director
Apologies:	None	
In attendance:	Rob Adamson	Head of Finance
	Susan Baines	Head of Financial Accounting
	Ian Black	Chair of the Trust
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Laurence Campbell	Non-Executive Director (designate)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Julie Fox	Non-Executive Director
	Paul Hewitson	Senior Audit Manager, Deloitte
	Debbie Hogg	Deputy Director of Finance
	Steven Michael	Chief Executive
	Clare Partridge	Director, KPMG (Head of Internal Audit)
	Dawn Stephenson	Director of Corporate Development
	Paul Thomson	Partner, Deloitte

AC/14/36 Welcome, introduction and apologies (agenda item 1)

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

AC/14/37 Minutes of the meeting held on 8 April 2014 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 8 April 2014 as a true and accurate record of the meeting. Matters arising will be taken at July's meeting.

AC/14/38 Consideration of the annual accounts for the period 1 April 2013 to 31 March 2014 (agenda item 3)

Report from the Director of Finance (agenda item 3.1)

Alex Farrell (AF) commented on the following.

- The work of the team and the processes followed have been excellent and supported by Deloitte.
- The surplus is largely to plan.
- The capital plan was re-profiled and the revised plan met.
- The Trust met its Monitor targets.
- The Trust has a strong cash position.
- The Trust delivered its cost improvement programme; however, there was an element of slippage/non-delivery and, as a result, £1.8 million additional non-recurrent savings were delivered.
- Her report contains an analysis of the key movements in-year.

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

Head of Internal Audit opinion (agenda item 3.2)
Clare Partridge (CP) confirmed that, as the Trust's internal auditor, KPMG was able to provide a substantial Head of Internal Audit Opinion. The overall opinion given was one of substantial assurance that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the Trust's objectives, and controls are generally being applied consistently.

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

ISA 260 Audit of Accounts 2013/14 (report to those charged with governance) (agenda item 3.3)
A final version of the ISA 260 was circulated. Paul Hewitson (PH) confirmed that there were no significant issues as a result of the audit and it was intended to issue an unqualified opinion on the accounts.

There was one audit adjustment in relation to a misstatement for a provision for HM Revenue and Customs (HMRC) of £194,000, which had been made prudently by the Trust. The provision was made in light of the HMRC decision to revoke guidance on VAT recovery and to re-issue later in the year. The Trust may or may not require the provision. Deloitte confirmed that it was required by auditing standards to report the misstatement; however, it was a matter for the Trust to agree whether to amend the accounts or not. AF responded that, as HMRC has not confirmed the position and, whilst accepting the observation made by Deloitte, at this point in time, the Trust wishes to retain the provision until revised guidance is issued. This was supported by the Committee.

Deloitte also identified four mismatches with the wider NHS over £250,000, which it is required to report to the National Audit Office (NAO). Deloitte is satisfied with the Trust's position but alerted the Committee under its duty to report to the NAO. Rob Adamson (RA) confirmed that these were as expected.

Two recommendations were made:

- that the Trust establishes a formal, legally-binding agreement for the Dales, which was accepted by management; and
- that the Trust should obtain signed contract variations before rendering services covered by the variations, which was also accepted by management.

Under the section relating to independence and fees, Ian Black (IB) asked if there should be reference to the work undertaken by Deloitte on the two-year operational plan. Deloitte confirmed that the audit fee relates only to work undertaken in 2013/14.

Letter of Representation (agenda item 3.4)
The Committee noted the addition (at point 19) in relation to redundancy provision. Deloitte has not had sight of copies of letters sent to staff but has confirmed with staff side that the process has begun and copies have been sent. This is purely a 'housekeeping' matter and Deloitte is satisfied that the provision has been made appropriately and a process is in place.

It was RESOLVED to APPROVE the Letter of Representation.

Before consideration of the accounts, PH asked whether there were any other matters the Audit Committee or management needed to bring to the attention of the auditor. The Committee and management confirmed that there were not.

Annual accounts and foundation trust consolidation schedules 2013/14 (agenda item 3.5)
RA alerted the Committee to one change in the accounts relating to the remuneration report (note 38.1) where the remuneration ratio has changed. **It was RESOLVED to APPROVE the change to the Accounts.**

PA commented on a potential disparity between the extent of redundancy provision whilst the Trust's headcount is increasing. As discussed in the pre-meeting, the Committee's preference would be to include an explanatory narrative in the annual report given Deloitte's advice this would not be appropriate for inclusion in the accounts. The Committee agreed this should be included in the section on staff. Bernard Fee (BF) reiterated his comment made in the pre-meeting that this position is counter-intuitive in the current climate.

It was RESOLVED to APPROVE the accounts for 2013/14.

AC/14/39 Annual report 2013/14 (agenda item 4)

The Chief Executive (SM) highlighted three changes to the Annual Governance Statement as a result of the review by Deloitte. Julie Fox (JF) asked for an explanation of parity of esteem on page 11 and a re-wording of the phrase "not felt to be statistically significant" on page 67. Subject to these amendments and the addition of wording agreed under item 3.5, **it was RESOLVED to APPROVE the annual report and the Annual Governance Statement for 2013/14.**

AC/14/40 Quality Report 2013/14 and auditor's report on the Quality Accounts (agenda item 5)

Tim Breedon (TB) introduced this item. The report demonstrates significant progress and the Trust's aspiration to improve. There had been a good response from partners and stakeholders. The report also demonstrates the Trust's approach to Francis and other external, national reports. Targets have been set for 2014/15, which are similarly stretching.

TB commented on the CPA 7-day follow up indicator. The Trust queried the definition of the indicator and it was clarified that other denominators should be included. Q4 performance was calculated under the revised guidance for the Monitor return. Monitor is of the view that the Trust does not need to re-state the figures for previous quarters. As the indicator is aimed at ensuring service users are safe and supervised following discharge, the Trust is satisfied that patient safety has not been compromised. This is a wider issue and will affect other Trusts as well as this one.

SM thanked Karen Batty for the excellent work in preparing the Quality Accounts for this year. It represents a consistency of approach over the last few years, which has paid dividends.

Deloitte confirmed that the report complies with the requirements of Monitor's annual reporting manual and that the content is consistent with other sources of information specified in Monitor's more detailed guidance. The Trust is green in both areas with no outstanding issues, given the inclusion of a glossary in the report. Deloitte commented that this was a really good document.

The third area of testing is of three indicators from a data quality perspective. An unmodified opinion was given on the mandatory indicator relating to gatekeeping. A number of recommendations were made in relation to this indicator, which have been accepted by management.

In relation to the other mandated indicator, CPA 7-day follow up, in Deloitte's view this represents a significant issue in terms of completeness of data. Its initial view was the Quality Accounts would be qualified as a result; however, Monitor has not asked the Trust to re-state its position nor has it asked other Trusts to review their data, which is an indication that this is a wider issue.

Deloitte has a meeting with Monitor on 27 May 2014. Deloitte's position and interpretation will be stated. If Monitor confirms that it accept Deloitte's position then Deloitte will issue an unqualified opinion. If not, Deloitte will suggest to the Trust that it includes a narrative and the revised performance against the target. Deloitte can then issue an unqualified opinion. Deloitte's position is that it does not want to qualify the Trust's Quality Accounts.

SM commented that the basis for the denominator does not reflect the intention of the indicator in ensuring safe and secure services and clinical reasons for the 7-day follow up target. AF commented that the Trust is in discussion with Monitor and has made a very strong case. Advice to the Trust currently is not to re-state the indicator. She agreed that the Trust should consider involving the Foundation Trust Network following Deloitte's meeting with Monitor should the need arise.

The issue represents a shift in the definition of the data. The audit trail of the change in interpretation and communication appears to be lacking in this instance. There is uncertainty that the drive behind the change is clinical; it is more to do with data completeness. The original measure represents a good indicator of the provision of quality and safe services.

Deloitte undertook to feedback to the Trust as soon as clarity is received and to the Audit Committee.

In relation to the local indicator, review of medication errors, although this has no impact on Deloitte's opinion, its view is that the definition of the indicator gives a misleading impression. TB responded that a number of recommendations have been made and the Trust has responded positively to these. The challenge from Deloitte was accepted.

Deloitte confirmed it was satisfied with the Trust's response to the recommendations and that it has followed up the recommendations from last year.

Subject to the outcome of further discussions with Monitor, i**t was RESOLVED to APPROVE the quality report for 2013/14.**

AC/14/41 Internal audit annual report 2013/14 (agenda item 6)

CP introduced KPMG's report and commented that the outcome of the internal audit programme for 2013/14 underpinned the Head of Internal Audit Opinion through substantial assurance given in core governance areas.

It was RESOLVED to NOTE the internal audit annual report for 2013/14.

AC/14/42 Any other business (agenda item 7)

PA thanked all Trust staff involved in the annual reporting process and thanked both internal and external auditors for their robust, co-operative and challenging approach.

PA also commented that this was BF's last meeting and that he was personally grateful to the contribution BF has made to the Audit Committee through his intuitive, pragmatic and

challenging approach. BF made his task as Chair much easier. SM added his thanks to BF in his role as Chair of the Clinical Governance and Clinical Safety Committee at such a difficult time. He provided pragmatic and clear leadership.

AC/14/43 Date of next meeting (agenda item 8)

The next meeting will be held on Tuesday 8 July 2014 at 14:00 in the Robin Norbury room, Kendray Hospital, Doncaster Road, Barnsley.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 6

Title:	**Annual report, accounts and Quality Report 2013/14**
Paper prepared by:	Directors of Finance, Corporate Development and Nursing, Clinical Governance and Safety
Purpose:	To enable Trust Board to receive and adopt the annual report, accounts and Quality Report for 2013/14.
Mission/values:	The annual report, accounts and Quality Report form part of the Trust's governance arrangements, which support the Trust's vision and goals. The annual report provides a summary of the Trust's performance, the accounts demonstrate financial probity and the Quality Report outlines the Trust's approach to quality and achievement of its quality priorities.
Any background papers/ previously considered by:	The full annual report, accounts and Quality Report for 2013/14 are available on request for members of Trust Board. This suite of documents will be available to the public once they have been laid before Parliament at the end of June 2014.
Executive summary:	<u>Background</u> The Audit Committee has delegated authority from Trust Board to review, scrutinise and approve the annual report, accounts and Quality Report. The Committee reviewed and approved the documents for 2013/14 at its meeting on 23 May 2014. The report and accounts with supporting documents were submitted to Monitor in line with the national timetable and have been submitted to the Department of Health for laying before Parliament. <u>Annual report 2013/14</u> The annual report was developed in line with Monitor's requirements and this was confirmed by the Trust's external auditors. The Committee approved the report. <u>Annual accounts 2013/14</u> The Audit Committee considered the report from the Director of Finance on the final accounts (attached for Trust Board), the Head of Internal Audit Opinion (see below) and the findings of the external auditors, Deloitte (ISA 260 attached for Trust Board). The Trust met all its financial targets and achieved a Monitor rating of 4. The Trust received an unqualified audit opinion on the 2013/14 accounts and a positive opinion on the requirement to demonstrate Value for Money. There was one mis-statement in the accounts, which was corrected, and there was no overall impact on the accounts as a result of this mis-statement. Two recommendations were made in relation to risk management and internal controls systems: 1. that the Trust establishes a formal, legally-binding agreement for the Dales, which was accepted by management; 2. that the Trust should obtain signed contract variations before rendering services covered by the variations, which was also accepted by management.

	The Head of Internal Audit Opinion for 2013/14 provided substantial assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. The Committee approved the accounts for 2013/14. <u>Quality Report</u> As requested by Trust Board, the Quality Report was scrutinised in detail by the Clinical Governance and Clinical Safety Committee prior to its presentation to the Audit Committee and a recommendation made for it to be formally approved. The Quality Report will be published on the NHS Choices website at the end of June 2014. The external assurance review conducted by Deloitte was received by the Audit Committee on 23 May 2014 (included in these papers for Trust Board). The audit reviewed the content against Monitor's Annual Reporting Manual and for consistency with other reporting mechanisms and found that: - the content was in line with guidance and consistent with documents reviewed; - the format reflected the recommendation to provide greater explanation of data tables; and - areas of good practice related to a clear statement of future priorities and how these will be achieved, use of tables and graphs, and the concise presentation of information. Deloitte also undertook a data quality review of two nationally mandated indicators (delayed transfers of care and access to crisis resolution teams). Trust Board is aware of the issue relating to the seven-day follow up indicator, which has subsequently been resolved with confirmation from Monitor that the Trust would not be required to re-state its performance for quarters 1, 2 and 3 of 2013/14. As a result, the required limited assurance opinion was issued. Deloitte also audited a local indicator in relation to the monitoring and measuring of medication errors. The overall conclusion was satisfactory subject to implementation of a number of recommendations, which have been accepted by management. The Committee approved the Quality Report for 2013/14. <u>Members' Council</u> The annual report, accounts and Quality Report and associated auditors' reports will be presented to the Members Council at the end of July 2014.
Recommendation:	**Trust Board is asked to receive and adopt the annual report, accounts and Quality Report for 2013/14.**
Private session:	Not applicable.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Director of Finance report on the annual accounts 2013/14
(Audit Committee 23 May 2014)

1.0 Introduction

The Audit Committee has delegated authority from Trust Board to scrutinise and approve the Trust's Annual Accounts for the financial year ended 31 March 2014, and to decide whether to recommend the Trust Board adopt these accounts. The Trust is required to submit its financial position for the period 1 April 2013 to 31 March 2014 to Monitor in the required format.

2013/14 represents the first year in which the Trust has submitted Consolidated Group Accounts. The purpose of this is to show the total resources that Trust Board has responsibility for and, as such, encompasses both the Trust's Accounts and the Trust's Charitable Funds activity.

The following report provides an analysis of the balances within the accounts and links them back to the overall Trust position reported in-year to Trust Board. The audited accounts, including details of senior managers' remuneration, were presented to the Audit Committee.

These accounts are made available to the public as part of the Trust's Annual Report; this report also includes details of the Trust's quality report. The content of the Annual Report has been reviewed by Audit to ensure it meets disclosure requirements. The Trust Board agreed the processes and approval of the Quality Report/Accounts through the Clinical Governance and Clinical Safety Committee. In addition, the Members' Council has a Quality Group, which is a sub-group of the Members' Council, which has been actively involved in the compilation of the Quality Report for 2013/14.

2.0 Trust Financial Performance 2013 / 2014 overall

The Trust's planned annual surplus for 2013/14 was £3.72 million; actual surplus was £3.75 million and overall was £33,000 better than planned. Capital expenditure for the year was £8.77 million against an original plan of £8.99 million which was broadly in line with plan. Various elements of the Capital Programme were revised in year with investment emphasis placed on updating inpatient facilities and ensuring that the infrastructure of main Trust sites are suitable for future Trust plans.

During 2013/14 Monitor's financial risk rating was revised to the Continuity of Service Risk Rating (COSRR). As at the end of March 2014, the Trust rated 4 as planned (with 4 being the highest possible rating).

The Trust's cash position remained strong throughout the year with sufficient resources to meet its outgoings. Surplus balances were reviewed in line with the Treasury Management Policy and as such have not been externally invested during 2013/14.

This presents the maximum financial benefit to the Trust.

Although not a requirement for Monitor, Trust Board supports the NHS better payment practice code which sets a target of paying 95% of valid invoices within 30 days of receipt, the Trust paid 95% of invoices within 30 days. In addition, the Government has requested all public sector bodies to pay small and medium sized suppliers within ten working days given the challenging economic climate; in response to this, the Trust paid 75% of local suppliers within ten days during 2013/14 to help sustain local communities. Work remains on-going to maintain and

improve these payment rates.

The Trust recorded delivery of £8.4 million of cost improvement programmes during 2013/14. Overall £1.8 million of the original plan was either delayed or substituted. Following review and mitigating actions, there was a £264,000 shortfall against the original plan.

3.0 Background

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

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

Deloitte will present their "ISA 260 Report – Communication of Audit Matters to Those Charged with Governance" to the Audit Committee. The report records any adjustments and audit amendments agreed in finalising the accounts and highlights any issues that have arisen during the audit.

3.1 Annual Accounts

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

3.2 Summarisation Schedules (FTCs)

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

3.3 Submission Deadlines and Adjustments

For 2013/14, the draft accounts were required to be submitted to Monitor and made available to Audit by 9:00 on 23 April 2014. The accounts were submitted on time. The audited accounts were submitted to Monitor by the required deadline of 30 May 2014. The audit commenced 28 April 2014.

3.4 Annual Governance Statement

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

The Trust is required to disclose any significant matters in the Annual Governance Statement. For this accounting period, the major strategic risks arose from the data quality and capture of clinical information on RiO, the care packages and pathways project and its ability to deliver improvement in service quality and outcomes, reduction in local authority funding and changes to the benefits system, planning and implementation of transformational change, inherited children's and adolescents' mental health services, changes to national funding arrangements, bed management pressures and specialist commissioning arrangements.

3.5 Accounting Policies

For 2013/14, the Trust updated its accounting policies in line with changes in accounting standards and associated guidance. Changes to these policies were discussed and approved by Audit Committee in October 2013 before adoption. There was no requirement for any prior period adjustments although the Group Consolidation exercise has required inclusion of additional prior

years' information as appropriate.

3.6 Major Judgement Areas

Trust Board has approved a challenging cost saving programme for 2014/15 and beyond. As a result, a number of posts are at risk and will result in a number of redundancies. This affects approximately 43 whole time equivalent (wte) posts during 2014/15 and 43 wte further redundancies during 2015/16. The Trust has estimated the associated redundancy costs and made provision for them in the 2013/14 accounts.

4.0 Analysis of the Annual Accounts

4.1 Statement of Comprehensive Income (Income & Expenditure Account)

4.1.1 Income

Total income for the year was £235.4 million (£232.4 million for 2012/13). This is split into income from healthcare activities and other operating income.

For 2013/14, the income from healthcare activities remained relatively static, increasing by £793,000. Income reduced from the previous year primarily due to tariff deflation applied through contract negotiations (as experienced nationally). Income increases arose from new income received in year (for example CAMHS, RAID).

Other operating income was £15.4 million in 2013/14 (£13.1 million 2012/13). This increased income arises from increased participation in the Trust lease car scheme and therefore higher contributions. This also includes additional funding for hosted budgets such as Altogether Better, specific projects and the accounting treatment for the impairment of assets.

4.1.2 Expenditure

Total operating expenditure increased by £5.4 million (2.3%) to £230.4 million (£225.0 million in 2012/13). Expenditure is detailed in note 6 of the accounts. The main changes are:

- Staffing costs and number of staff employed are in note 7 of the accounts.
- Staff costs have increased by £1.8 million (1.0%). This increase is a combination of a staff pay award being received in 2013/14 and additional staffing for services such as CAMHS, RAID and Health Visiting.
- Overall, the average wte employed by the Trust has remained broadly static as additional staff, as noted above, have been offset by reductions including the impact of the Trust Mutually Agreed Resignation scheme.
- Non pay costs have increased by £2.5 million. The largest increases have been the inclusion of the Trust impairment and additional expenditure on out-of-area placements. These have been offset by reductions in non-pay expenditure in most areas/categories.

4.1.3 Operating Surplus

The Trust's 2013/14 operating surplus before dividends and interest is £5.2 million; the surplus in 2012/13 was £7.5 million and is therefore a reduction of £2.3 million.

This movement is reflective of the Trust expectations within the Annual Plan.

4.1.4 Interest

Interest received on bank deposits during the year was £88,000 (£374,000 2012/13). No interest payments were made during the year. This is in line with the Trust's Treasury Management Policy and the amendments to the Public Dividend Capital (PDC) calculation. Whilst higher rates of interest (although not as high as previously experienced) could have been achieved with external investment, maintaining funds with the Government Banking Service has realised the greatest overall financial benefit.

4.1.5 Public Dividend Capital (PDC)

Public dividend capital dividend payable during the year amounted to £1.5 million (£1.6 million 2012/13). Part of this reduction is due to the positive cash balances held by the Trust and needs to be considered in conjunction with the Interest Received position as described at 4.1.4.

4.1.6 Retained Surplus

The Trust's retained surplus after interest, taxation, depreciation and amortisation for 2013/14 was £3.8 million (£6.0 million 2012/13). No financial support was provided to the Trust during the year and the Trust received no loans.

4.2 Statement of Financial Position (Balance Sheet)

4.2.1 Non-Current Assets (Fixed Assets)

Non-Current Assets have increased by £34.6 million from 2012/13 (7.3%). This totals £103.8 million. The largest element of this change is due to the transfer of assets from NHS Barnsley on 1 April 2013.

Intangible Assets

Intangible assets have increased in year by £316,000 due to the transfer of software licences from NHS Barnsley (note 13 in the accounts).

Property, Plant and Equipment – PPE

Note 14 of the accounts provides details of the changes in PPE. In summary, the changes reflect an increase for the capital expenditure less any depreciation during the reporting period, and include the impact of any asset revaluation. A total of £8.4 million was included as additions to capital assets during 2013/14. The main schemes included:

- completion of the major Newton Lodge scheme and commencement of the Hepworth inpatient facilities scheme for forensics;
- commencement of the Fieldhead infrastructure scheme;
- The purchase of Laura Mitchell House (Halifax) enabling development of the Calderdale hub.

Total depreciation for the year was £5.0 million.

Investment Property

There has been no change to the value of Trust investment property in-year and remains valued at £0.4 million.

4.2.2 Stock

Over the twelve month period there has been a £278,000 reduction in stock. This follows a review of stock within the Barnsley Community Equipment Store. There has been no change in counting or accounting policy around stock.

4.2.3 Trade and Other Receivables (Debtors)

Receivables have increased by £2.1 million. Further detail is provided in note 20 of the accounts. The main factor in this increase has been the transfer of block contract income from local health commissioners to local authority commissioners. This has been experienced throughout the course of the year with payments being received but later than previously experienced. This is demonstrated by the level of debt which is 0 – 30 days overdue.

4.2.4 Cash

Cash at bank and in hand was £33.1 million as at 31 March 2014 (£29.9 million at 31 March 2013).

4.2.5 Trade and Other Payables (Creditors)

Trade and other payables have increased by £3.0 million overall on last year. Further detail is provided in note 22 of the accounts.

Of this £1.9 million relates to a specific NHS invoice for which appropriate backing information is being sought to allow full and appropriate authorisation to be undertaken. Due to the timing of the capital programme there has also been an increase in the level of capital creditors as the Trust is awaiting invoices for work undertaken in Quarter 4.

4.2.6 Provisions (Current and Non-Current)

There has been an overall reduction of £0.9 milli0n in provisions over the period. This mostly relates to the in-year utilisation of previous provisions for redundancy costs. The total provision

at 31 March 2014 is £7.2million (£8.1 million 31 March 2013). The remaining provisions relate to pensions and other legal claims liabilities as detailed in note 25 of the accounts.

4.2.7 Other liabilities (Current and Non-Current)

These relate to deferred income which has increased to £0.84 million in 2013/14 (£0.79 million in 2012/13). The majority of this relates to the hosted budgets for Altogether Better.

There are no prior period adjustments.

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

Details of all reserve movements for the accounting period are on page 4 of the accounts. The main movement for the year relates to the transfer of assets from NHS Barnsley on 1 April 2013. Other movements include the retained surplus for the accounting period and the impact of the revaluation exercise.

4.3 Statement of Cash Flow – Page 5

The Trust has £33.1 million of cash as at 31 March 2014 (£29.9 million at 31 March 2013). This is an increase of £3.2 million (9.7%).

The increase arises from £13.2 million within the EBITDA position (excluding non-cash items and re-valuations), £0.3 million movement in inventories and £3.2 million increase in creditors.

The interest received in the period was £88,000.

Cash outflows included capital expenditure £7.4 million and £1.4 million for dividend payments. It also included the movement in debtors and the reduction in accruals values.

4.4 Remuneration Report

The Trust is required by its Regulators to make available to the public details of senior managers' remuneration. Full remuneration and pension reports have been included in the Annual Report and in the accounts at note 38. The format of this note has been revised for 2013/14.

At time of producing the annual report and accounts, Directors' Performance Related Pay had still to be finalised for 2013/14. The disclosure reflects the payment received during 2013/14 which is the value awarded for 2012/13.

The Remuneration ratio has reduced from 7.0 to 6.4. This is due to the retirement of a Director with significant exit costs and does not reflect an underlying trend.

Alex Farrell
Deputy Chief Executive/Director of Finance

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview

Month 2 2014/15

Table of Contents

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 2 2014/2015 (May 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	A/G
• Annual community survey	A/G

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

FIT FOR THE FUTURE WORKFORCE	
• Sickness	A/R
• Training	A/G
• Appraisal	Not available

Trust Board Performance Dashboard – Vital Signs (Month 2 2014/15)

Business Strategic Performance: Impact & Delivery

Month 2 2014/15

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	4	✓	–	4
CQC	CQC Quality Regulations (compliance breach)	Green	Green	✓	–	4
CQUIN	CQUIN Barnsley	Green	Amber/G	▲	–	3
	CQUIN Calderdale	Green	Amber/G	▲	–	3
	CQUIN Kirklees	Green	Amber/G	▲	–	3
	CQUIN Wakefield	Green	Amber/G	▲	–	3
	CQUIN Forensic	Green	Amber/G	▲	–	3
IAPT	IAPT Barnsley: % Who Moved to Recovery	50%	48.21%	✓	↓	3
	IAPT Kirklees: % Who Moved to Recovery	52%	52%	✓	↓	3
	IAPT Outcomes - Barnsley	90%	98.43%	✓		4
	IAPT Outcomes - Calderdale	90%	97%	✓		4
	IAPT Outcomes - Kirklees	90%	100%	✓		4
Inf' Prevent'	Infection Prevention (MRSA & C.Diff) All Cases	8	0	✓	–	4
C-Diff	C Diff avoidable cases	0	0	✓	–	4
PSA Outcomes	% SU on CPA in Employment	10%	**7.8%**	✗	↑	3
	% SU on CPA in Settled Accommodation	60%	**72.2%**	✓	↑	4

Customer Focus

Month 2 2014/15

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 25%	17% 4/23	✓	↓	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%	47%	▲	↓	3
	% 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%	▼	–	2
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	> 70%	75%	✓	↑	4
	% 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 2 2014/15

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	95%	99.8%	✓	↑	4
	Max time of 18 weeks from point of referral to treatment - incomplete pathway	92%	98.7%	✓	↑	4
	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**4.18%**	✓	↓	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**100.00%**	✓	–	4
	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	96.35%	✓	↓	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**94.00%**	▲	↓	4
	Meeting commitment to serve new psychosis cases by early intervention teams QTD	95%	207.97%	✓	↑	4
	Data completeness: comm services - Referral to treatment information	50%	100%	✓	–	4
	Data completeness: comm services - Referral information	50%	94%	✓	–	4
	Data completeness: comm services - Treatment activity information	50%	94%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.40%**	✓	–	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**84.70%**	✓	↑	4
	Compliance with access to health care for people with a learning disability	Green	Green	✓	–	4
Data Quality	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**99.1%**	✓	↑	4
	% Valid NHS Number	99%		●	●	4
	% Valid Ethnic Coding	90%		●	●	3
Mental Health PbR	% of eligible cases assigned a cluster	100%	95.7%	✗	↑	
	% of eligible cases assigned a cluster within previous 12 months	100%	80.2%	✗	↓	

Fit for the Future; Workforce

Month 2 2014/15

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Appraisal	% of Staff Who Have Had an Appraisal in the Last 12 Months	>=90%				
Sickness	Sickness Absence Rate (YTD)	<=4%	4.8	▼	↓	3
Vacancy	Vacancy Rate	10%	3.5%	✓	–	4
Safeguarding	Adult Safeguarding Training	>=80%	72.25%	▲	↑	3
Fire	Fire Attendance	>=80%	74.75	▲	↑	3
IG	IG Training	>=95%	89.31	▲	↓	4

Overall Financial Position

Performance Indicator		Month 2 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	
Trust Targets					1	-	-		
1	Monitor Risk Rating equal to or ahead of plan	●	●	↑	●			4	-
2	£2.58m Surplus on Income & Expenditure	●	●	↑	●			4	-
3	Cash position equal to or ahead of plan	●	●	↑	●			4	-
4	Capital Expenditure within 15% of plan.	●	●	↓	●			4	-
5	Delivery of Recurrent CIP	●	●	⇔	●			4	-
6	In month Better Payment Practice Code	●	●	⇔	●			4	-

Summary Financial Performance

1. The Financial Risk Rating (Risk Assessment Rating) is 4 against a plan level of 4. A score of 4 is the highest possible.

2. The year to date position, as at May 2014 is showing a net surplus of £1.3m which is £1.1m ahead of plan.
Overall the current BDU forecast positions require the utilisation of provisions (£1m) in order for the Trust to forecast a balanced surplus position. Work continues within all areas of the organisation to ensure that cost pressures are mitigated and expenditure reductions are maximised.

The largest singular cost pressure identified by the Trust relates to additional Out of Area expenditure (payments made to 3rd parties for the provision of Healthcare). This is an unfunded cost pressure and the current forecast includes a pressure of £1m.

3. At May 2014 the cash position is £31.29m which is £0.42m ahead of plan.

4. Capital spend to May 2014 is £0.53m which is £0.66m (55%) behind the Trust capital plan. The overall Capital Plan is currently being revalidated. Based upon current performance a resubmission of the Capital Programme will be required to Monitor at Quarter 1.

5. At Month 2 the Cost Improvement Programme is £0.13m ahead of plan of £1.73m. (7.3%) Based upon current knowledge it is forecast that there will be a £1.29m shortfall (outstanding schemes rated as red) and therefore further substitute schemes will need to be introduced.

6. As at 31st May 2014 (Month 1) 94% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%).

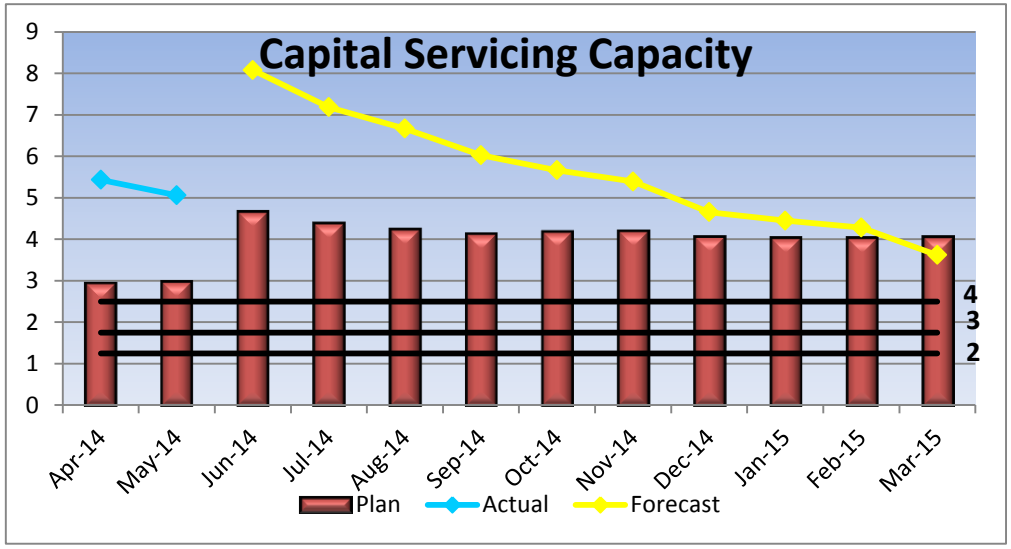
Monitor Risk Rating

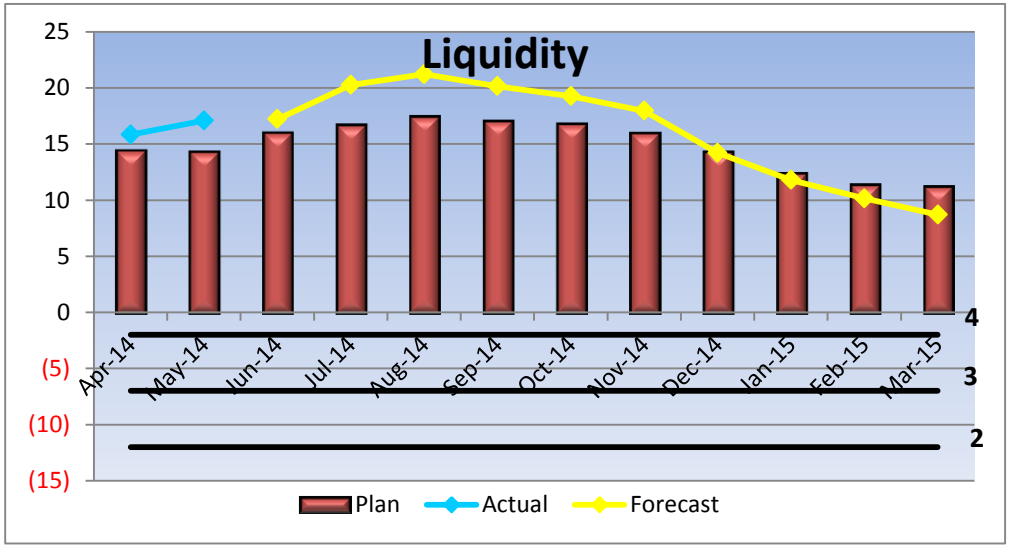
Continuity of Service Risk Rating 2014 / 2015				
	Actual Performance		Annual Plan May 2014	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	5.1	4	3.0	4
Liquidity	17.1	4	14.3	4
Weighted Average		**4**		**4**

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

There is currently no expectation that this will be lower than a 4.

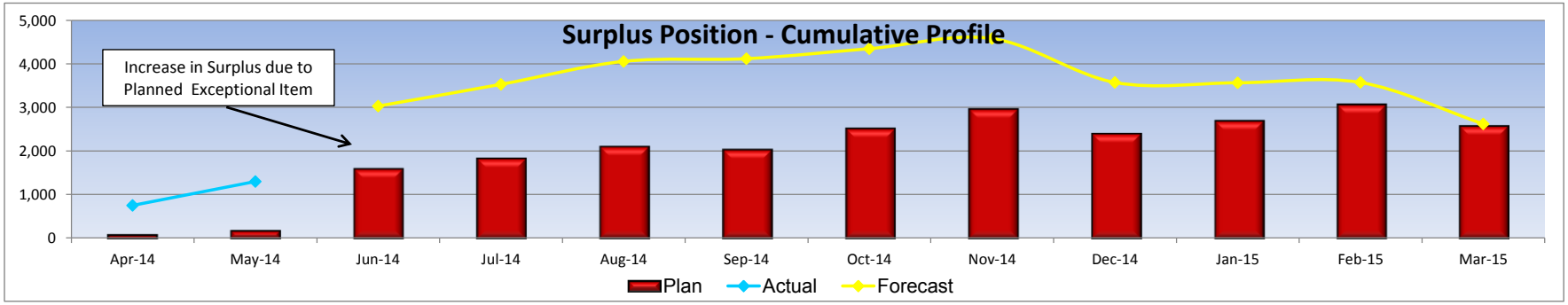
Both ratios are currently better than planned.





Income & Expenditure Position 2014 / 2015

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(18,121)	(18,095)	26	Clinical Revenue	(36,290)	(36,276)	14	(217,839)	(217,675)	164
				(18,121)	**(18,095)**	**26**	**Total Clinical Revenue**	**(36,290)**	**(36,276)**	**14**	**(217,839)**	**(217,675)**	**164**
				(1,070)	(1,200)	(130)	Other Operating Revenue	(2,065)	(2,265)	(200)	(12,340)	(13,012)	(673)
				(19,191)	**(19,295)**	**(103)**	**Total Revenue**	**(38,354)**	**(38,541)**	**(186)**	**(230,179)**	**(230,687)**	**(508)**
4,547	4,390	(157)	3.5%	14,528	14,312	(216)	BDU Expenditure - Pay	29,008	28,398	(609)	171,298	171,919	622
				3,705	3,597	(108)	BDU Expenditure - Non Pay	7,358	7,158	(200)	44,008	44,971	962
				162	157	(5)	Provisions	355	331	(24)	4,636	3,612	(1,024)
4,547	**4,390**	**(157)**	**3.5%**	**18,395**	**18,066**	**(329)**	**Total Operating Expenses**	**36,721**	**35,888**	**(833)**	**219,942**	**220,502**	**560**
4,547	**4,390**	**(157)**	**3.5%**	**(796)**	**(1,229)**	**(432)**	**EBITDA**	**(1,634)**	**(2,653)**	**(1,020)**	**(10,237)**	**(10,185)**	**52**
				433	422	(10)	Depreciation	865	845	(21)	5,191	5,191	0
				264	264	0	PDC Paid	527	527	0	3,164	3,164	0
				0	(7)	(7)	Interest Received	0	(15)	(15)	0	(89)	(89)
				0	0	0	Impairment of Assets	0	0	0	(700)	(700)	0
4,547	**4,390**	**(157)**	**3.5%**	**(100)**	**(550)**	**(450)**	**Surplus**	**(241)**	**(1,296)**	**(1,055)**	**(2,582)**	**(2,620)**	**(37)**



The information above represents the plan, and phasing associated with this, as per the 2 year plan submitted to Monitor in April 2014.
This includes the planned phasing impact of the Trust Cost Improvement Programme, as shown within the CIP information.

Overall the Trust surplus position, as at May 2014 / month 2 is £1,296k. This is £1,055k better than planned. The main element of this is:

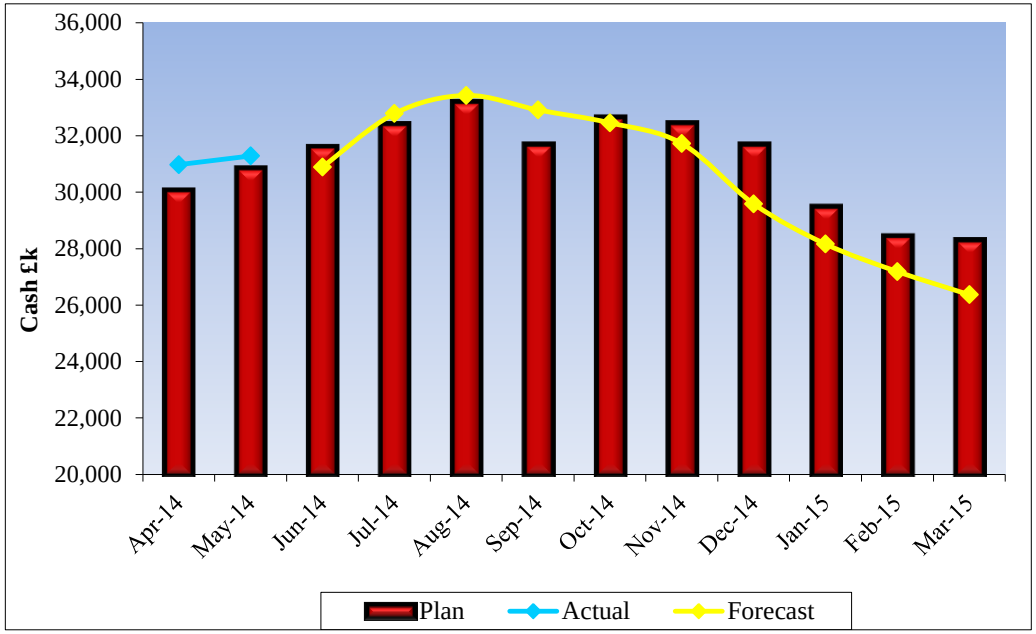
* Pay underspends across all BDU's with the expenditure on pay being less than budgeted including taking account of the impact of bank, agency and locum staff.

However the forecast at month 2 highlights a number of risk areas / financial pressures which will need to be addressed. These include:

* Identified risks around cost reductions / savings within the Cost Improvement Programme. These continue to be the subject of management review and implementation. At this point in time plans are yet to be finalised and as such have been RAG rated as red and are reflected in the forecast. In the original plan the majority of these were designed to be delivered in Quarters 3 and 4.
* BDU cost pressures, the largest of which relates to additional costs from Out of Areas expenditure.

Overall the current BDU forecast positions require the utilisation of provisions (£1m) in order for the Trust to forecast a balanced surplus position. Work continues within all areas of the organisation to ensure that cost pressures are mitigated and expenditure reductions are maximised.

Cash Flow Forecast 2014 / 2015



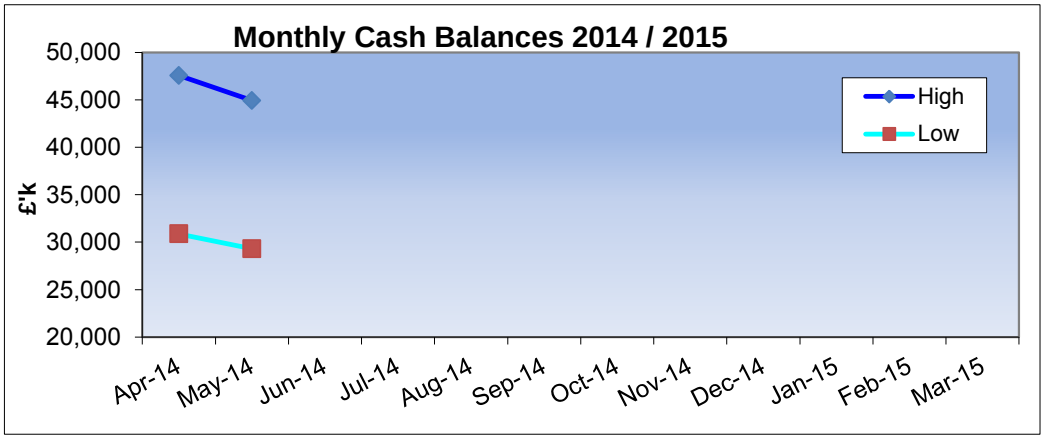
	Plan	Actual
	£k	£k
Opening Balance	33,114	33,114
Closing Balance	30,866	31,285

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

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

Overall the cash position for May 2014 is £31.29 m which is £0.42 m ahead of plan.

The current cashflow forecast is being validated, and action taken specifically with the balance sheet position, to improve this current forecast position (for example action to tackle the level of Non NHS debtors).



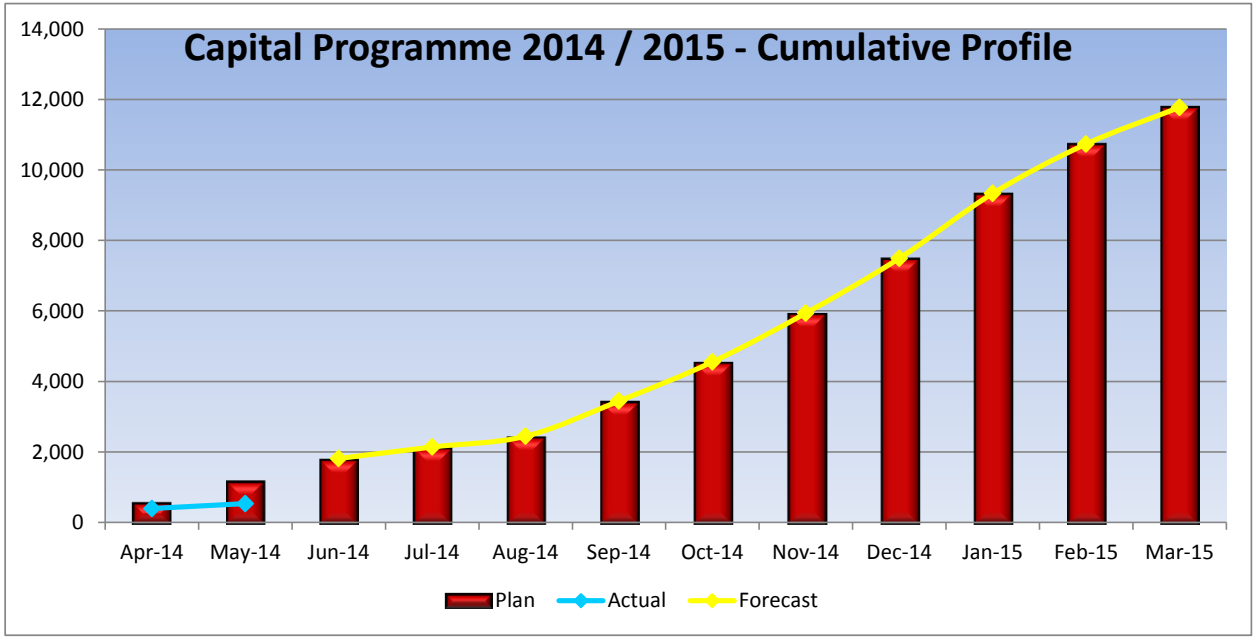
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £44.93m.
The lowest balance is : £29.29m.

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

Capital Programme 2014 / 2015

Capital Expenditure Plans - Application of funds	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,294	448	54	(394)	2,294	0	*5*
Total Minor Capital	**2,294**	**448**	**54**	**(394)**	**2,294**	**0**	
Major Capital Schemes							
Hub Development / Hepworth	6,644	448	274	(174)	6,644	0	*3*
Fieldhead Hospital Development	2,392	284	178	(105)	2,392	0	*4*
IM&T	450	15	25	10	450	0	
Total Major Schemes	**9,486**	**747**	**478**	**(269)**	**9,486**	**0**	
VAT Refunds				0	0	0	
TOTALS	**11,780**	**1,196**	**532**	**(663)**	**11,780**	**0**	*1, 2*



Capital Expenditure 2014 / 2015

1. The total Capital Programme for 2014 / 2015 is £11.78m

2. The year to date position is £663k under plan (55%) when compared to the Monitor plan for month 2.

The main reasons behind this variance are:

3. £234k variance to plan in relation to Forensics inpatient redevelopment. Approximately £200k of this relates to expenditure recognised in 13/14. The scheme overall is forecast to spend in line with plan. This additional funding will be utilised within the overall Capital Programme.

* This is partially offset by expenditure on the Calderdale Hub development which is £71k ahead of plan.

4. Underspend arising from Infrastructure (£72k) and Decant Facilities (£33k)

5. Underspends against Facilities (£215k) and Small Schemes (£145k) have been addressed and a revised spending plan has been put in place to bring back in line with profile.

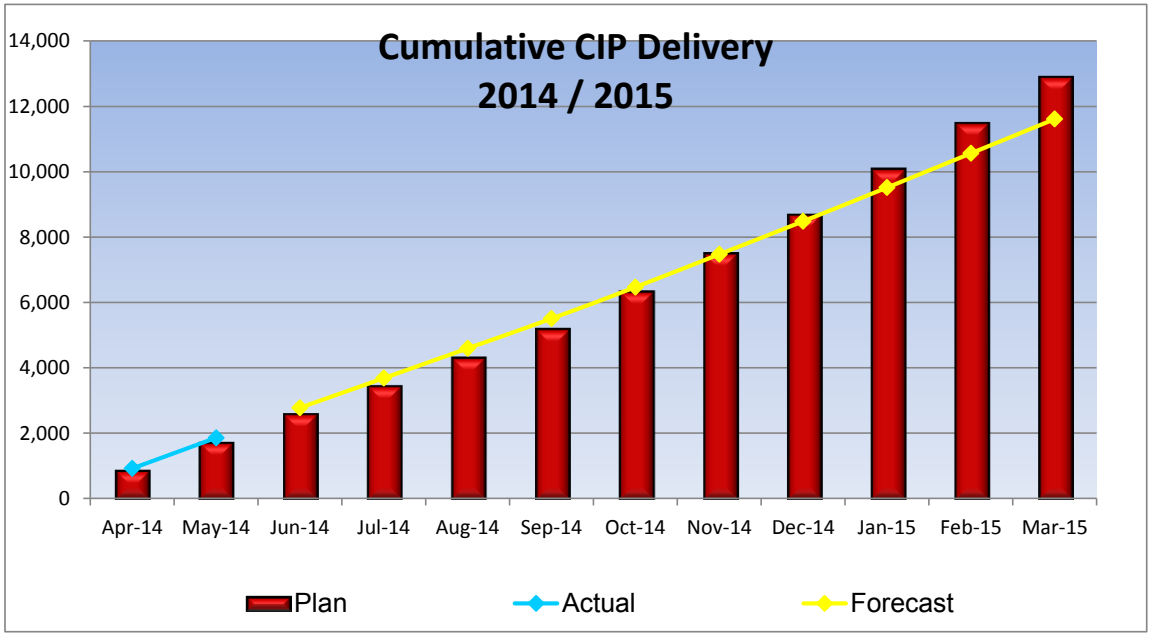
* This includes Minor Works Scheme (£50k) delayed pending review.

Overall the Capital Programme is forecast to be fully utilised and a revised profile will be reviewed as part of the Quarter 1 Monitor return.

Summary Performance of Cost Improvement Programme

Delivery of Cost Improvement Programme 2014 / 2015

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Monitor Submission	864	864	864	868	868	868	1,159	1,159	1,182	1,400	1,400	1,400	1,727	12,898
Target - Cumulative	864	1,727	2,591	3,459	4,328	5,196	6,355	7,515	8,697	10,097	11,497	12,898	1,727	12,898
Delivery as planned	809	1,643	2,461	3,269	4,067	4,862	5,701	6,546	7,393	8,257	9,120	9,983	1,643	9,983
Mitigations - Recurrent	65	130	196	259	337	417	506	600	696	797	913	1,030	130	1,030
Mitigations - Non Recurrent	41	80	116	151	187	222	258	325	392	460	528	596	80	596
Total Delivery	**914**	**1,854**	**2,773**	**3,680**	**4,591**	**5,502**	**6,465**	**7,471**	**8,481**	**9,513**	**10,561**	**11,610**	**1,854**	**11,610**
Shortfall / Unidentified	(51)	(126)	(182)	(220)	(264)	(306)	(110)	44	215	584	936	1,288	(126)	1,288



The profile of the Trust Cost Improvement Programme for 2014 / 2015 is outlined above. This profile demonstrates the Trust's plan to deliver increased savings through the year.

The current position is a £84k shortfall against the original plan. However substitutions actioned by BDU's mean that the Trust is ahead of plan at month 2 by 126k. The overall forecast is a £1288k shortfall as schemes planned for later in the year are currently not finalised.

This is based upon information available at this current time and it's a prudent assessment of delivery. This has been reflected within the overall Trust forecast position.

Work is being undertaken but has not yet been finalised and therefore is not included within this month 2 position. This will be reflected once actions are agreed and implemented.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to April 2014	97.4%	93.7%
Year to May 2014	93.7%	93.1%

Non NHS		
	Number	Value
	%	%
Year to April 2014	97.0%	94.0%
Year to May 2014	96.4%	93.0%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to April 2014	83.5%	65.3%
Year to May 2014	82.2%	63.3%

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 94% 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 96% 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 82% of Local Supplier invoices by volume and 63% by the value of invoices within 10 days.

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 1 the Trust's self-assessed risk rating is green.

2 Care Quality Commission (CQC)

- The timescale for completion of identified interventions in regard to the 2 compliance actions related to the CQC visit to Fieldhead (Forensic and Trinity 2) has now passed. It should be anticipated that the CQC will make a return inspection visit fairly soon.
- There has been a further delay to the completion of the CQC Fox View report. The latest intelligence is that the Trust should expect to receive this within 3 to 4 weeks.

1.3 CQUINs

1.3.1 Barnsley

Overall Performance Rating : Amber/Green

The majority of the schemes for 2014/15 are new, with only the National NHS Safety Thermometer for Pressure Ulcer prevalence building on a local scheme in Barnsley already in place.

Key Risk Areas:

- National CQUIN - improving physical healthcare within Mental Health. Risks associated with ensuring ICD codes are recorded and full recording of cardio metabolic factors are completed.
- Local CQUIN – NHS Safety Thermometer – maintenance of current position for BDU already performing well in the national picture.
- Local CQUIN – Pressure Ulcers - Improve pressure ulcer prevention and management. Reduce deterioration and service improvement following learning. Some potential risks associated with achievement of thresholds Q2 onwards.
- Local CQUIN (NHSE) Health Visiting Services – risk associated with improved prevalence of breastfeeding at 6-8 weeks within the health visiting service.

1.3.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green

All schemes with the exception of the National Safety Thermometer and Service User experience are new for 2014/15

Flawless Execution Continued

Key Risk Areas:

- National CQUIN - Improving Physical Healthcare - The main concern is in relation to the Patients of CPA indicator and how the success of achievement with this CQUIN is dependent upon the inter-dependencies between SWYPFT and GPs.
- Local CQUIN - Service User Experience - represents the biggest area of risk for non-achievement based on 2013/14 performance averaging 75% achievement.

1.3.3 Forensic

Overall Performance Rating: Amber/Green

Key Risk Areas:

- National CQUIN – Improving Physical Healthcare. Risks relate to interdependencies with GP's as identified in other BDU's

1.4 IAPT - % Moving to Recovery - Barnsley

Increased in the numbers entering treatment and DNA rate have negatively impacted on this KPI. The service are working to minimise this negative impact.

1.5 PSA Outcomes

Month 2 data shows a continued under performance against the national Department of Health outcome measures % on CPA in employment (Target >10%).
Position in Barnsley, Calderdale, Kirklees and Wakefield has improved compared to Month 1. Wakefield 6.6%, Kirklees 8.8%, Calderdale 8.9%, Barnsley 6.1%

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 Data Quality

Work on-going within BDUs to reduce risk related to the introduction of financial penalty for non-achievement related to a number of KPI's. Amber/Green Risk associated with Ethnic coding and 7 Day FU at BDU level – BDU Data Quality Action plans being reviewed.

Flawless Execution Continued

3.2 CPA Reviews

Deterioration in performance in month 2 takes the Trust position just below threshold (94%). Forecast is to achieve at quarter end and this is being monitored within BDU's.

3.2 Mental Health Currency Development

External

Workshop took place with commissioners 19 May to discuss 2014/15 changes to MH Currencies agenda and future shadow contract arrangements. The overall feedback was positive

The Trust volunteered for an external audit by CAPITA on the quality of clustering and costing. This has been received and will be reviewed by EMT. Overall the quality of data on costing was assessed as good ; the report did pick up issues re data quality as anticipated.

The 2 High priority recommendations around accurate clustering were to:-
1) Ensure patient notes contain a complete record or presentation and
2) Clearly identify and document the assessment scores to ensure cluster accuracy.

CPPP training group are working to develop an e-learning package that will simplify training, improve consistency and accuracy of MHCT scoring / cluster allocation. It is hoped that this will be approved by Royal College of Psychiatrists with the potential that it could in future be marketed.

Internal

The revised performance indicators for 2014/15 are on schedule to complete the set up for first submission of quarter 1 to CCGs then monthly thereafter.

A simplified core assessment form has completed the pilot phase in Barnsley and has now been rolled out to the rest of the BDUs. The assessment form was designed by clinical staff co ordinated by the Medical Director. The redesign objective was to streamline generally been well received by clinical staff.

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Flawless Execution Continued

3.2.1 Mental Health Clustering

Data Quality Monitoring – Trust Wide Performance - May

Measure	Trust	Calderdale	Kirklees	Wakefield	Barnsley
% Total eligible Service users on caseload - clustered	96%	96%	97%	98%	92%
No of eligible Service users on caseload - clustered	20472	3174	7047	5662	4589
% Adherence to Care Transition Protocols	93%	90%	94%	95%	94%
% of Service Users Reviewed within Cluster frequency	73%	68%	66%	81%	75%
Care Coordinator Recorded	89%	90%	83%	93%	91%

4.0 FIT FOR THE FUTURE: WORKFORCE

4.1 Appraisal - (End of April position) – 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 – Trustwide Position (End of April position) – 4.84% Overall.

Slight rise from financial year end rate of 4.69% Trustwide in March 2014. The overall position for April 2014 shows an increase from the same position last year which stood at 4.69% for April 2013. The 4.84% rate for April 2014 is the highest rate within the Trust for the month of April since 2009.

- **Current Year to Date (YTD) Sickness Absence Rates by BDU (End of April Position).** Absence projection figures to be published from month 3 data onward following analysis of absence trends, historic data and future potential trends.

	Current YTD absence rate	Absence Projection to March 2015	Current Absence Rate Trend
Barnsley BDU	5.07%	TBC	Increasing
Calderdale BDU	4.15%	TBC	Increasing
Forensic BDU	7.11%	TBC	Increasing
Kirklees BDU	5.06%	TBC	Decreasing
Specialist Services	5.05%	TBC	Increasing
Support Services	4.15%	TBC	Increasing
Wakefield BDU	3.21%	TBC	Decreasing

Flawless Execution Continued

- **Fire Training (Trustwide End of May Position) – 74.7% (Target – 80%). Increase from 74.4% last month**

- Barnsley BDU: **74.3% -** decrease from **75.5%**
- Calderdale BDU: **73.4% -** decrease from **77.9%**
- Forensics BDU: **83.4% -** increase from **82.8%**
- Kirklees BDU: **72.4% -** increase from **68.0%**
- Specialist Services BDU: **69.9% -** decrease from **75.4%**
- Support Services BDU: **76.9% -** decrease from **79.9%**
- Wakefield BDU: **73.7% -** decrease from **79.5%**

4.4 Information Governance Training – 89.31%% (Target – 95%)

The position at the 7th working day after the end of the month based on a rolling 12 period is 89.3%. This is a small reduction from 90.5% last month. The number of staff who are currently not up to date with their training are 504. Although the numbers falling due for the training are low in the first quarter of this year any member of staff who is not up to date with their training may pose a risk to the organisation in the event of a breach of confidentiality.

- Barnsley BDU: **88.1% -** decrease from **90.7%**
- Calderdale BDU: **91.2% -** decrease from **92.8%**
- Forensics BDU: **88.8% -** decrease from **90.1%**
- Kirklees BDU: **88.5% -** decrease from **90.6%**
- Specialist Services BDU: **86.4% -** decrease from **87.4%**
- Support Services BDU: **89.8% -** decrease from **90.4%**
- Wakefield BDU: **94.6% -** decrease from **95.9%**

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	ental Health Clustering Tool
MRSA	ethicillin-Resistant Staphylococcus Aureus
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
NHSE	NHS England
OH	Occupational Health
OPS	Older People's Services
PbR	Payment by Results
PREM	atient 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

Trust Board Performance Dashboard - Key

✓	Green	▲	Amber/Green
✗	Red	▼	Amber/Red
↑	Performance has improved	-	No assurance level assigned
–	Performance maintained or target met and assurance 4	1	Forecast not met; no plan/plan will not deliver
↓	Performance has declined	2	Forecast high risk not met; plan in place but very unlikely to deliver
●	Not Applicable	3	Forecast risk not met; plan in place but unlikely to deliver
N/A	Not Applicable	4	Forecast met; no plan required/plan in place likely to deliver

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 7.3(i)

Title:	**Customer Services annual report for the financial year 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	This report supports Trust Board scrutiny of complaints about care and treatment provided by Trust services. Trust Board is asked to receive the report and note the learning as a consequence of feedback through the Trust's Customer Services function.
Mission/values:	Good customer service underpins all six of the Trust's stated values and is central to fostering and maintaining a culture of continuous quality improvement and improved outcomes for people who use services.
Any background papers/ previously considered by:	The Trust Board also receives quarterly reports on Customer Services activity.
Executive summary:	This report covers the financial year 2013/14 and gives an overview of issues raised through the Customer Services function during the period. The Trust aims to improve the experience of people who use services by responding positively to feedback and resolving issues as they happen whenever possible and at every level in the organisation. During the period covered by the report: • 338 formal complaints were investigated, with learning shared as appropriate • 171 informal concerns, 814 enquiries and 137 comments were made • 762 compliments were corporately recorded and shared • 206 requests for information under Freedom of Information Act were processed (an increase on the previous year of 73). Customer Services activity increased in the year across all areas, reflecting the increased range of services provided and continued active promotion of the function and ways to offer feedback. The team continues to work with teams and services to support a positive response to feedback, and to review this from both the perspective of the service user and from that of staff. In the coming year, the Trust will maintain a focus on maximising opportunities to understand service user experience and to share learning to improve services in response to feedback, both internally with teams and externally with commissioners and local Healthwatch.
Recommendation:	**Trust Board is asked to note the management of issues raised through Customer Services in 2013/14 and to note this in the broader context of ongoing work in relation to understanding service user experience.**
Private session:	Not applicable

TRUST BOARD – 24 JUNE 2014

CUSTOMER SERVICES - ANNUAL REPORT FOR THE FINANCIAL YEAR 1 APRIL 2013 TO 31 MARCH 2014

INTRODUCTION

This report provides information regarding feedback received by the organisation through the Customer services function in the financial year 2013/14.

The report covers all feedback received by the team – comments, compliments, concerns and complaints, which are managed in accordance with policy approved by the Trust Board.

The Customer Services function provides one point of contact at the Trust for a range of enquiries and feedback and offers accessible support to encourage feedback about the experience of using Trust services.

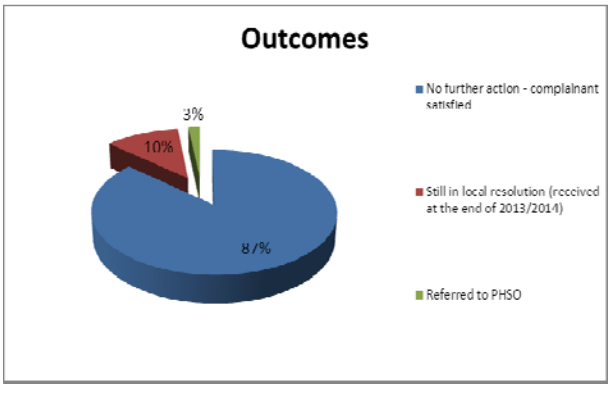
This report includes:

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

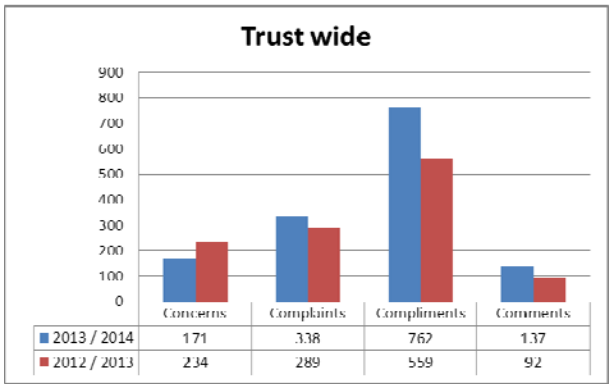
FEEDBACK RECIEVED

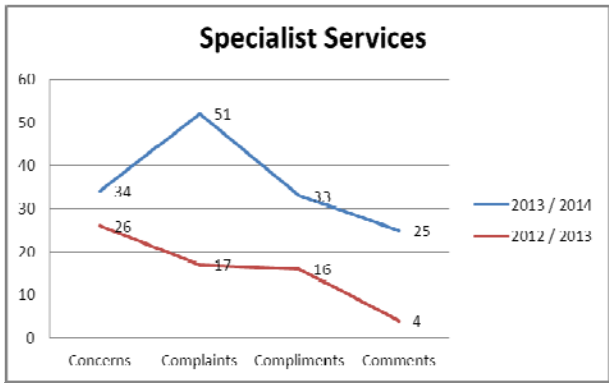
The table below illustrates Customer Services activity in 2013/14. The number of formal complaints received in the year was 338, which is an increase on the last two years, when 289 and 275 complaints were recorded respectively. This increase reflects the increased range of services now provided and perhaps the active promotion of the Customer Services function to service users, carers and staff and the wide distribution of materials explaining how to raise an issue to support improved service provision.

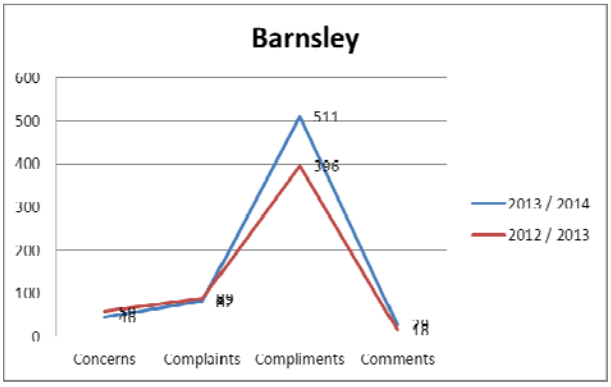
FORMAL COMPLAINTS PROGRESSION

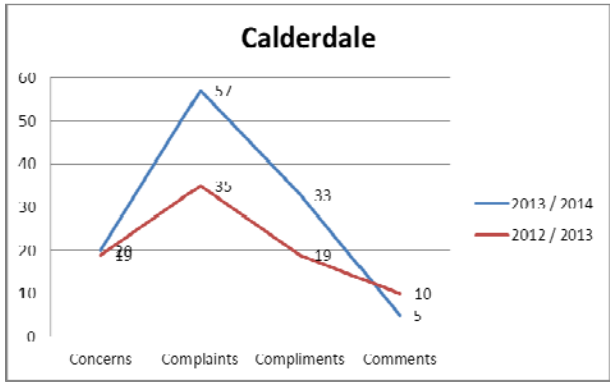


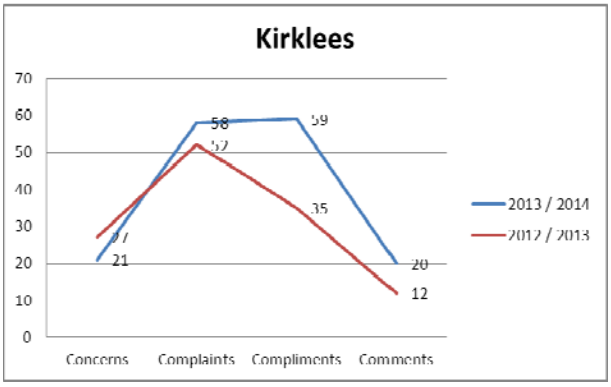
CUSTOMER SERVICES ACTIVITY 2013/14

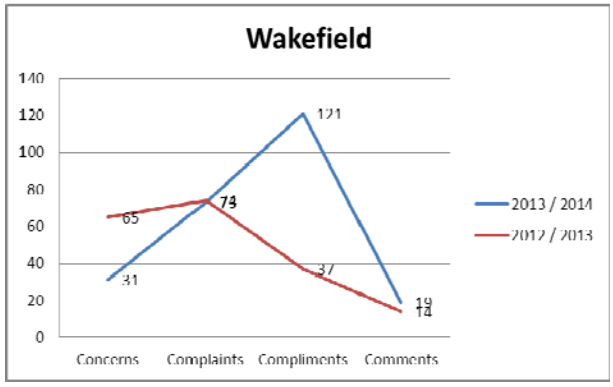


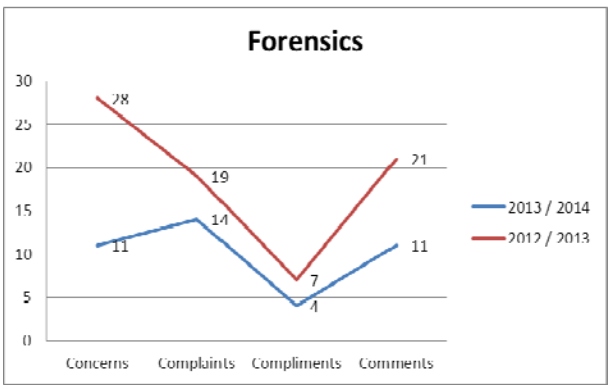


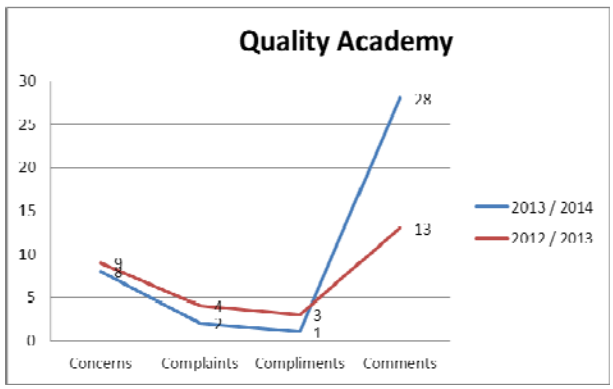












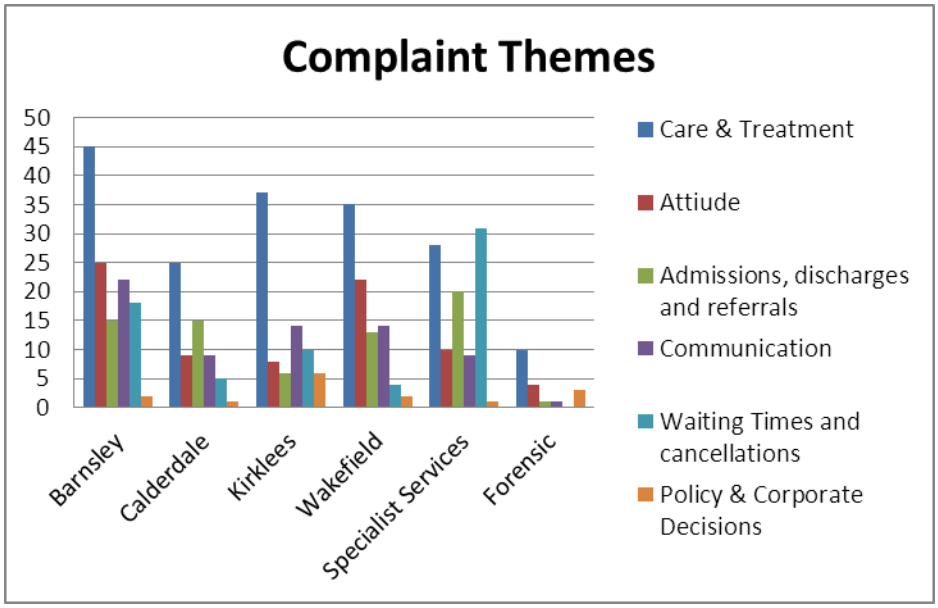
NUMBER OF ISSUES RAISED INFORMALLY

During the year, Trust services responded to 308 issues of concern and comments at local level. The Customer Services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right as and when they happen wherever possible and supports shared learning about service user and carer experience.

THEMES

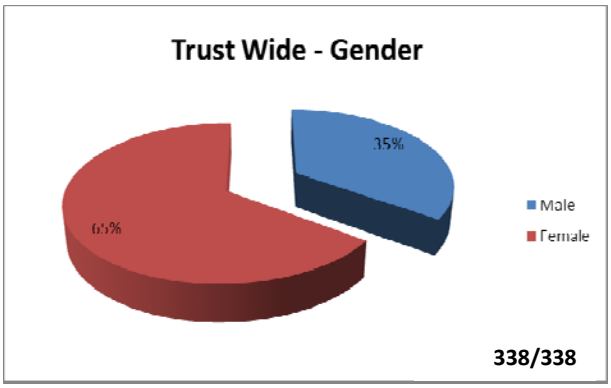
Consistent with past reporting, care and treatment was the most frequently raised negative issue (180). This was followed by staff attitude (80), admission, discharge and transfer issues (71), communication (70), waiting times (68) and policy and corporate decisions (27). Most complaints contained a number of themes.

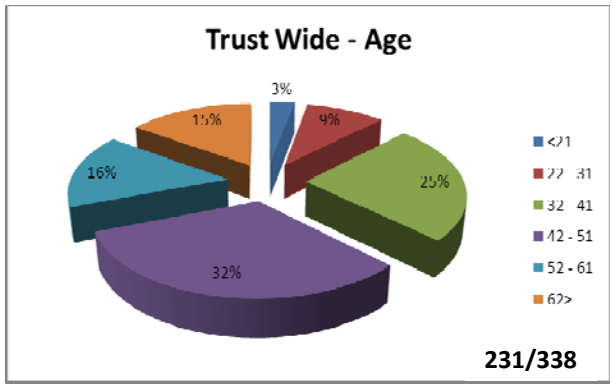
The Customer Services function connects to a weekly risk scan which brings together intelligence from the Patients Safety Support Team and the Legal Service Team to triangulate any issues of concern and assess the impact on service quality.

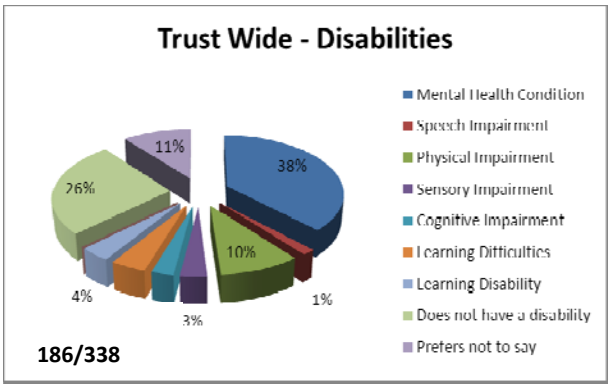


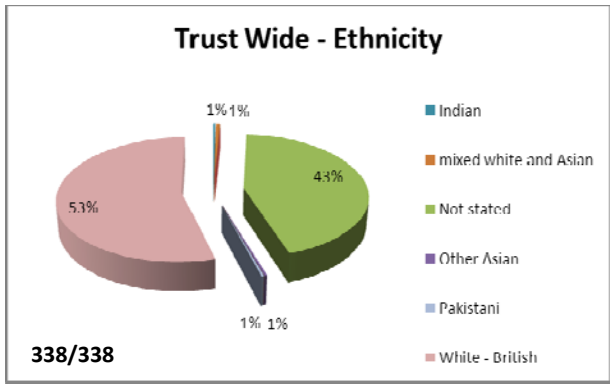
EQULITY DATA – TRUST WIDE

Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. The current average response rate for forms is 81%. The charts that follow show where information was provided, the breakdown in respect of gender, age, disability and ethnicity. The total number of complaints received and information provided across the characteristics is shown in each table.









MP CONTACT

During 2013 /14, there were 24 occasions where complaints and feedback were received via local MPs, acting on behalf of constituents. MP enquiries are processed in line with routine practice and contact made direct with individuals wherever possible.

Barnsley BDU: Dan Jarvis MP
Seven enquiries: medication, waiting time for therapy, perceived lack of support from crisis services (3), funding issue, discharge from services

Calderdale BDU: Linda Riordan MP
One concern regarding medication and the type of therapy offered.

Forensic BDU: Ed Balls MP
One enquiry regarding visiting times and leave

Kirklees BDU: Jason McCartney MP (3) and Mike Wood MP (1)
Four enquiries – access to CBT, access to duty team, perceived lack of support regarding care plan and cancellation of appointment.

Specialist Services BDU: Barry Sheerman MP (1), Simon Reevell MP (2), Yvette Cooper MP (1), Craig Whittaker MP (1)
Five enquiries - four regarding access to CAMHS and one regarding perceived delay in assessment by ADHD service.

Trust wide – Yvette Cooper (MP)
One issue in relation to Open Arms (service user led group offering peer support to people with Mental Health Issues) which no longer receives financial support from Local Authority.

Wakefield BDU – Jon Trickett MP (1) Yvette Cooper MP (2) Mary Creagh MP (1)
Four enquiries – medication, staff attitude, perceived lack of support from a CMHT and one issue in relation to a medical report sent to the DVLA.

External to Trust: Jason McCartney MP
Report requested in regards to service user's mental health in relation to social housing issue.

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

At the start of the financial year, 5 cases were open for consideration by the PHSO (2 Kirklees, 2 Barnsley and 1 Wakefield BDU). During the 2013/14, six complainants (2 Wakefield, 1 Kirklees, 1 Calderdale, 1 Forensics and 1 Barnsley) asked the Ombudsman to review their cases. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes.

During the year:

- 4 cases were closed by the Ombudsman with no further action
- 4 cases were resolved through financial redress in sums recommended by the Ombudsman (reflecting the Ombudsman's changing stance in the area of redress).
- 1 case was concluded, through Local Government Ombudsman and Parliamentary and Health Service Ombudsman joint working, the results of which were published on the LGO website in November 2013. The Trust and Kirklees Council accepted the findings and recommendations and all actions for agreed remedy have been completed (including financial redress)
- 2 cases were awaiting a decision at the end of the year.

MENTAL HEALTH ACT

22 complaints were made in the year with regard to service user detention under the Mental Health Act. 15 of these were raised by people describing themselves as white British, 1 person described themselves as 'other' ethnicity and 6 elected not to specify ethnicity. Information on the numbers of complaints regarding application of the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

CARE QUALITY COMMISSION (CQC)

During 2013/14 the CQC referred a complainant to the Trust who had approached them directly. The complaint related to Wakefield BDU and was in relation to restraint and medication issues. The Trust responded directly to the complainant, advising the CQC of the response. There was no contact from the CQC in respect of complaints management.

JOINT WORKING

National guidance emphasises the importance of organisations working jointly where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

The Customer Service function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. During 2013/14, in addition to routine

requests, feedback was provided in relation to a national study regarding issues affecting deaf and hard of hearing people.

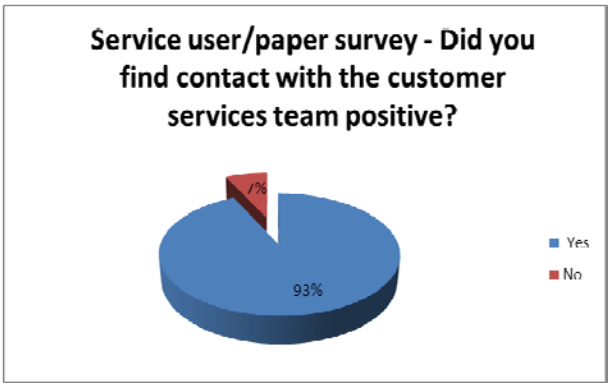
Issues spanning more than one organisation in 2013/2014	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Barnsley Hospital NHS Foundation Trust	2	0	0	2
Barnsley Metropolitan Borough Council	4	0	0	4
Calderdale and Huddersfield NHS Foundation NHS Trust	4	0	0	4
Care Quality Commission	2	0	0	2
Cygnet Hospital - Harrogate	1	0	0	1
Harrogate and District Foundation NHS Trust	1	0	0	1
Kirklees Council	1	0	0	1
Mid Yorkshire Hospital NHS Trust	2	0	0	2
NHS Barnsley	1	0	0	1
NHS Barnsley CCG	4	1	0	5
NHS North Kirklees CCG	1	0	0	1
Other	2	0	1	3
Sheffield Teaching Hospital	1	0	0	1
Yorkshire Ambulance Services NHS Trust	1	0	0	1
Total	27	1	1	29

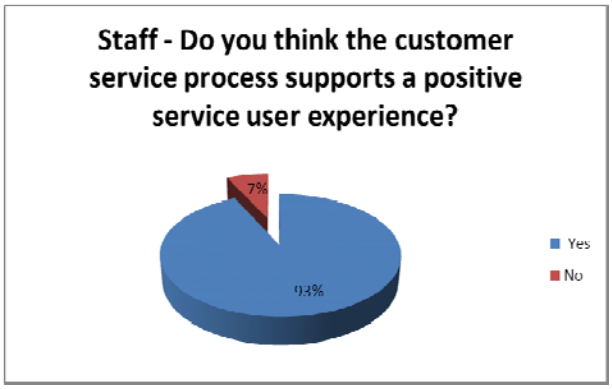
CONTACT WITH THE CUSTOMER SERVICES TEAM

The customer services team processed 814 general enquiries in 2013 /14, in addition to '4 Cs' management. These included provision of information about Trust Services, signposting to Trust services, providing contact details for staff and signposting to involvement activities and dialogue groups. The team also responded to over 2500 telephone enquiries from staff, and offered support and advice in resolving concerns at local level.

In responding to contact of any kind, the team negotiates with individuals regarding the timescales for responding to issues and regular contact is maintained until issues are resolved to the individual's satisfaction. This connection results in positive feedback to the service regarding complaints management.

A range of survey material has been introduced to evaluate the customer services offer and improvements have been made to processes in response to feedback. The Customer Services Team has recently introduced telephone surveying of service users, to supports real time feedback and improved responsiveness. This will be reported on in future quarterly reports.

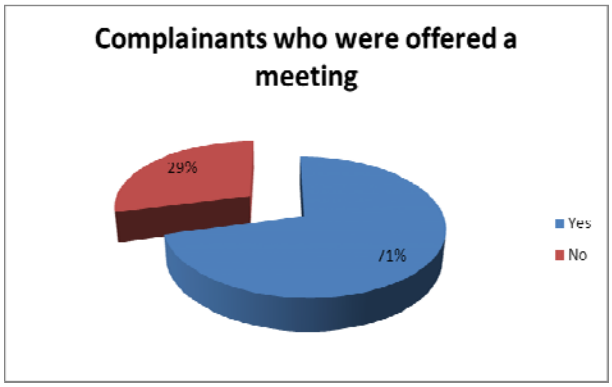




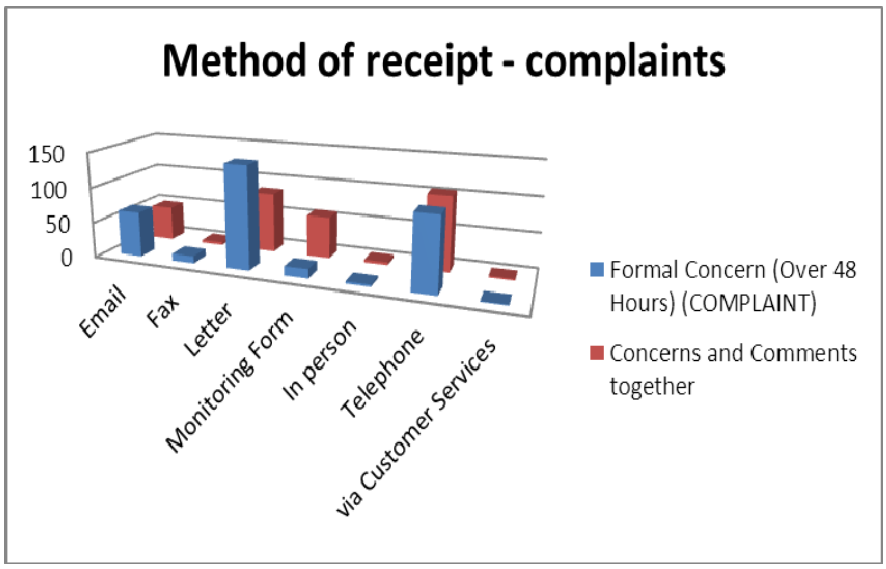
The Trust recognises that it is good practice to offer complainants the opportunity to meet staff to discuss issues. This offer is made early in the process, especially when complaints relate to more serious issues or complex circumstances. These meetings are ideally attended by both Customer Services and service staff and provide an opportunity for staff to reflect on the experience from the service user's perspective.

Feedback from staff shows that this improves overall understanding of how people who use services and their families are affected by the contact. Most complainants agree to meet with Trust staff to discuss their concerns.

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



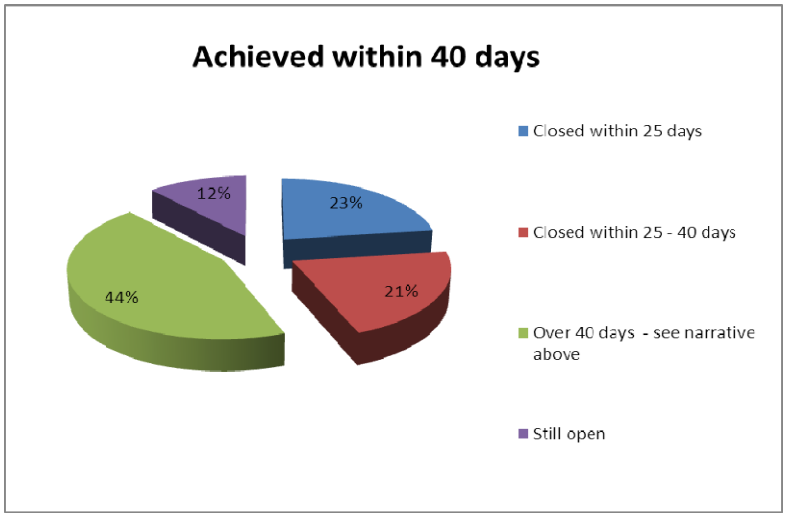
Complainants may wish to communicate in writing (by letter or completion of the Customer services feedback form), over the phone, by email, via the website or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is an essential to delivering the Trust's values and is part of how we ensure that people have a say in public services. The Customer Services function is part of a developing framework of activity to facilitate feedback about all aspects of services and ensuring any lessons learned are acted upon. The team is currently working with speech and language therapy colleagues to develop materials to promote the service which are suitable for people with a learning disability.



RESPONDING IN A TIMELY MANNER

The customer services standard is for complaints to be acknowledged within three days, with a named case worker assigned. Timescales are negotiated on an individual basis, with each complainant offered regular updates on progress until issues are resolved to their satisfaction or a full explanation has been provided. All complaints are dealt with as speedily as possible. The standard is for every complaint to be responded to within 25 days; or 40 days for the most complex cases. In 2013/14, 44% of cases took longer than the 40 day internal service standard, and 21% exceeded the preferred 25 day standard. This was due to:

- Consent to investigate not received from complainant or from service user
- Further issues added to the complaint requiring additional investigation
- Capacity issues determined by responsible clinical
- Cases awaiting further information or clarification
- Cases re-opened following Trust response
- Staff absence caused delay in obtaining witness statements
- Complaint put on hold at the complainants request.



COMPLIMENTS

During the year 762 compliments were recorded. These are acknowledged by the Chief Executive and positive feedback is shared with the individual, the team and across the Trust through the Trust intranet to ensure other services are influenced by good practices across the Trust

Some compliments received in year:

I have been in this hospital many times but I am especially grateful for the treatment I have received this time. This is by far the best experience I have had of being in hospital. Thank you for everything.
Barnsley Palliative Care

We would like to thank the nurse who attended the last appointment. We were so impressed with her approach and how caring she was. We were so happy and pleased after the appointment.

Kirklees Memory Service

I cannot praise you enough. I am extremely grateful of your support.

Specialist Services

Congratulations for the work staff do at Newton Lodge.

Forensic Service

Thank you for all the help and support given without the help and support your service gives there would be many more people suffering with their mental health problems
Wakefield Psychology Services

I wanted to tell you how impressed I was with all the staff, at all levels. They showed great patience and sensitivity and my mother's condition improved enormously whilst in their care

Calderdale Inpatient Service

Key words quoted in compliments received in the period:

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

Not all complaints require action plans to remedy issues, but all provide helpful feedback which is used in services to support service improvement. District Directors monitor the delivery of action plans and ensure that corrective action is implemented within service lines in response to trend analysis provided by Customer Services.

Most complainants meet with Trust staff to discuss their concerns. All complainants received a detailed response to the issues raised and an apology where appropriate. Action taken and changes implemented in response to feedback include:

Barnsley BDU

- District nursing services have implemented new procedures to ensure family members/carers are provided with updates and action plans where appropriate.
- The continence service now ensures all service user manual records are checked against electronic records to ensure consistency
- A CMHT is working collaboratively to ensure effective joint crisis contingency plans are in place
- The Physiotherapy team is currently reviewing the process of self-referral into services to ensure it meets service user needs and is responsive to feedback
- A district nursing team has improved record keeping following a review, for example no ‘copy and paste' entries to avoid incorrect data entry / wrong record entry.
- A community mental health team is reviewing its discharge process, with a service user group working with staff to agree the most helpful discharge information
- Staff in a community mental health team are to be provided with additional information and training in regards to Asperger’s syndrome.
- District nursing staff will liaise more closely with care agencies to ensure a shared understanding of issues raised and improve partnership working.
- District nursing staff will provide training and support to agency staff to enhance patient care.
- A Community Based Intervention Team will only divulge information personal to themselves if they are sure it is received in the context of enhancing the therapeutic relationship with an individual.
- A number of improvements have been made to the Physiotherapy/Musculoskeletal processes for managing appointments:
    - Staff will make sure that they are available to take self-referral calls between the hours advertised by the service. Staff will also be mindful to manage expectation regarding appointment wait times
    - Senior Physiotherapist to be notified upon receipt of each referral. Physiotherapists and students to ensure full clear explanations are given to service users regarding particular techniques before treatment commences.
    - A new call queuing system in being put in place.

Calderdale & Kirklees BDUs

- Staff in a community mental health team have introduced further checks on service user information and consent status prior to sharing information with any third party.

- A CMHT is to offer one to one meetings as an alternative to a full multidisciplinary team meeting. The service has also reformatted the care review meeting summary sheet, adding a request for attendees to leave a meeting if a service user requests this.
- The IAPT services have increased capacity to enable thorough signposting to appropriate services to best suit the needs of individual service user
- The inpatient ward will ensure full explanations are provided to service users/family members/carers regarding bed management and out of area placements.
- Inpatient staff have been instructed to ensure that next of kin and other family members contact details are stored on Rio and subject to regular update. This follows a review of the admission procedure and checklist.
- A ward is to introduce a comprehensive education programme to improve the level of understanding for carers of people living with dementia. The ward is also putting in place improved levels and management of observations, and an engagement plan to improve the ward environment. This will focus on all aspects of risk associated with a service user's care, including mobility.
- An inpatient ward has improved communication to ensure carers and family members fully understand the reasons behind bed availability and the Trust's bed management protocol.
- Secretarial staff in the IAPT service has been reminded to check that details are correct on appointment letters before sending them out.
- Staff in a Kirklees CMHT now liaise with care home managers to ensure that care plans are always shared with hospital ward staff or A&E staff (as is the procedure on transfer from a mental health ward to an acute hospital).

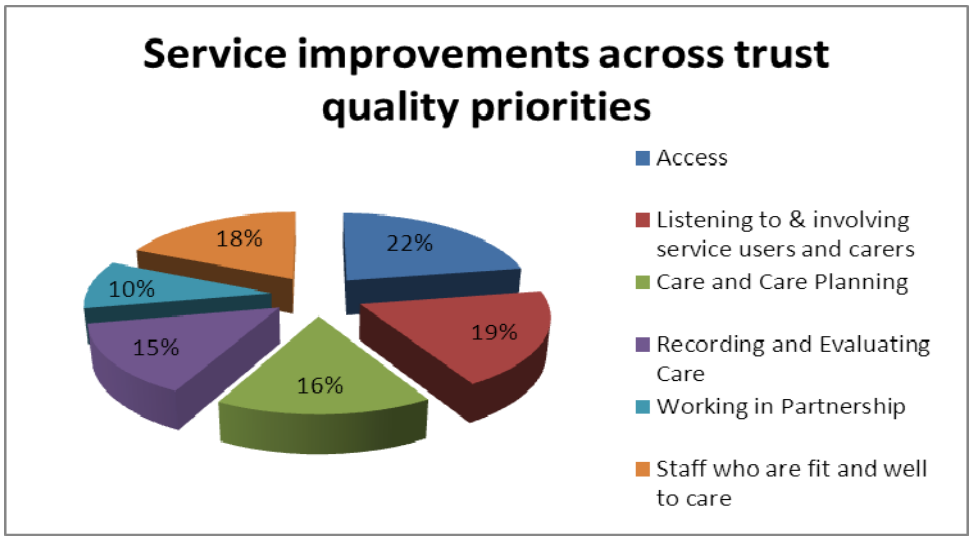
Wakefield BDU

- An inpatient ward has reviewed the process for communicating with service users about the ward environment
- More information is now provided to service users and carers about mental health assessment in a crisis team
- An inpatient service is reviewing the process of admission for staff or former staff to take account of preferences for 'out of area' care
- People who work in voluntary roles have been provided with additional information regarding the need to be mindful of confidentiality.
- An inpatient ward now ensures that the use of leave beds is fully explained to service users who leave the ward for periods of home leave.
- A Psychology team will ensure that practitioners responsible for discharging always check that services users are informed about and understand their discharge and how to access follow up services. Practitioners will also ensure all appropriate referrals to other services have been actioned prior to discharge.
- Training is being provided in a CMHT regarding Court of Protection and the responsibilities of the Deputy.

Specialist services BDU

- The Kirklees CAHMS service is currently reviewing staff attendance at Children and Family meetings to ensure a full overview is provided.

Improvements were made across the Trust's quality priorities as follows:



EXAMPLES OF SERVICE USER AND CARER EXPERIENCE

Amy raised concerns that three of her appointments showed in her records as DNAs, where in fact, 2 appointments had been cancelled by the CAMHS service and she never received a further appointment. The investigation showed that Amy and her family experienced poor communication as a result of poor administration.

An apology was offered along with an explanation of the improved administrative procedures put in place to minimise future errors. Records were amended to reflect that missed appointments were the fault of the service

Tina – contacted the customer services team to raise concerns regarding the length of time she had waited to be seen by the podiatry team in Barnsley. Tina also raised concerns regarding cancellation of clinic appointments and how referrals to the clinic were reviewed

As a result of Tina's feedback, the service has now put in place a revised system for receiving and allocating referrals, alongside implementing methods for to address the increasing demand placed on the service through the volume of referrals.

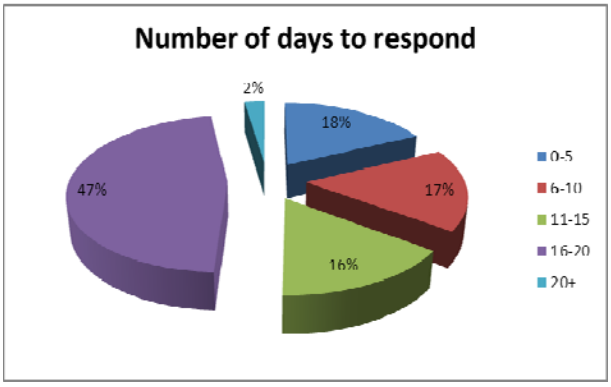
Colin raised concerns that he felt all aspects of his care has not been shared with him and that he had not received a copy of his care plan.

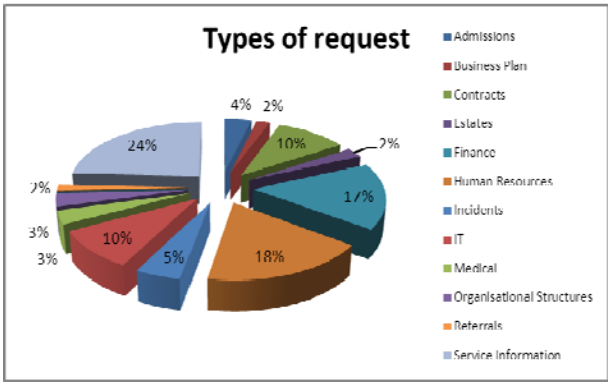
Staff in a Kirklees BDU community mental health team now ensure service users are provided with a copy of their care plan and that this is clearly documented within health care records.

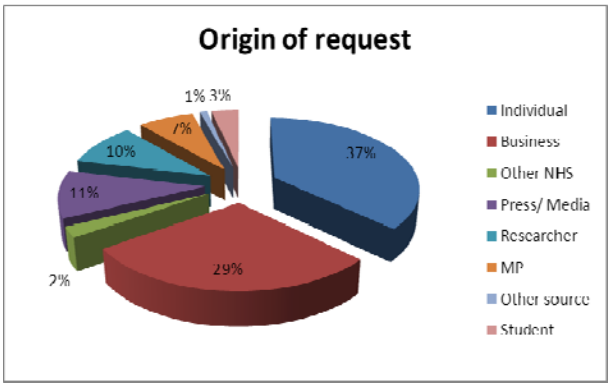
FREEDOM OF INFORMATION REQUESTS

206 requests to access information under the Freedom of Information Act were processed in the financial year 2013/14, an increase of 73 on the previous year. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

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







During the year, two requests were subject to exemptions under the Act - one under section 43 - public sector contracts and commercial interest, and one under section 22 - information intended for future publication. Two requests were not responded to within the 20 day requirement; due on both occasions to the Trust waiting for clarification of information requirements from the requestor.

There were no complaints or appeals against decisions made in respect of management of requests under the Act during the year.

LOOKING FORWARD

Customer Services efforts continue to focus on gathering insight into service user experience and to support teams to develop action plans to change and improve services as a consequence of feedback.

The Trust's Customer Services Policy: management of complaints, concerns, comments and compliments ensures compliance with national standards in respect of NHS complaints handling and takes account of other relevant publications. The policy was revised in December 2013 to take account of:

- The increased emphasis on gaining insight into people's experience of using services to influence how services are organised and new services are planned.
- Recommendations arising from the Francis Report, and the Government's response, Hard Truth's, The Patients Association report on NHS complaints and the Rt. Hon Ann Clwyd's review of NHS complaints management
- The policy includes reference to the Parliamentary & Health Service Ombudsman's evolving stance on redress
- Policy and procedures in relation to response to feedback and complaints management are currently being reviewed in light of the introduction of the duty of candor.

The policy includes revised reporting arrangements for complaints, including formal quarterly reporting to Trust Board. Quarterly reports are also shared with Extended EMT, externally with commissioners as part of the contracting process, and with Healthwatch across our geography. Monthly reporting on complaints regarding staff attitude continues as part of the Trust's performance report.

The Trust has ceased production of the quarterly report 'What Matters', which promoted positive practice across quality priorities. Reporting is being developed from that of snapshot reporting of positive experience to a dashboard of agreed KPIs, incrementally reported to influence and change behaviours and ensure an optimum service user experience. This work is being progressed as part of the service user experience sub group of the Equality & Inclusion Trust Action Group.

EMT will also consider how to build customer focussed KPIs into the 'Year of Values' work in the current financial year. Initiatives, now incorporated into the year of values programme, which support an improved service user experience are continuing, for example, the 'Right First Time, Every Time training programme.

There is also agreement for a team recognition scheme for those teams that demonstrate they 'live the values' in the delivery of their work. This will be launched in the coming weeks, will run to the end of the financial year 14/15, and be subject to evaluation.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 7.3(ii)

Title:	**Appraisal/revalidation annual board report 2013/14**
Paper prepared by:	Medical Director
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the Statement of Compliance
Mission/values:	Medical Revalidation aims to strengthen the way that doctors are regulated, and thus improve the quality of care provided to patients, improve patient safety and increase public trust and confidence in the medical system.
Any background papers/ previously considered by:	Previous papers to Trust Board on Medical Revalidation in October 2009, November 2010, December 2010, April 2011, October 2011, March 2012 and November 2012
Executive summary:	NHS England requires each Designated Body to produce an annual Revalidation Board Report, incorporating details reported in the Annual Organisational Audit. Out of 149 doctors with a prescribed connection with the Trust as at 31 March 2014, 141 successfully completed the appraisal process during 2013/14. Six doctors had an agreed postponement in line with the medical appraisal policy and this was approved by the AMD for Revalidation. Two doctors exceeded the time frames and were not authorised to do so. One of these doctors had a period of sickness absence and the other suffered a bereavement in the midst of the appraisal process. There were 23 revalidation recommendations required from 1 April 2013 and 31 March 2014, all of which were completed on time. One doctor with an imminent revalidation recommendation was a relatively new employee to the Trust and had recently changed specialty. The Trust was unable to provide appropriate supporting information and, in consultation with the GMC Liaison Employment Advisor, the decision was made to defer for one year. The increasing demands from NHS England to ensure the quality assurance of the process may lead to further financial pressures on the Trust and, as a result, consideration is being given for a business case for further administrative support. The Medical Appraisal Policy covers appraisal and revalidation processes and includes an Equality Impact Assessment and an Equality Statement confirming equality and diversity statutory duties have been met.
Recommendation:	**Trust Board is asked to accept the report and approve the statement of compliance confirming that the organisation is a designated body as in compliance with the regulations.**
Private session:	Not applicable

APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2013-14

1. Executive Summary

Out of 149 doctors with a prescribed connection with the Trust as at 31st March 2014, 141 successfully completed the appraisal process during 2013/14. Six doctors had an agreed postponement in line with the medical appraisal policy and this was approved by the AMD for Revalidation. Two doctors exceeded the time frames and were not authorised to do so. One of these doctors had a period of sickness absence and the other suffered a bereavement in the midst of the appraisal process. There were 23 revalidation recommendations required from 1st April 2013 and 31st March 2014, all of which were completed on time. One doctor with an imminent revalidation recommendation was a relatively new employee to the Trust and had recently changed specialty. We were unable to provide appropriate supporting information and in consultation with the GMC Liaison Employment Advisor the decision was made to defer for 1 year.

2. Purpose of Paper

The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the Statement of Compliance (see appendix 6).

3. Report Format

NHS England have required this template is used by Trusts for their annual Board Report. This format has only recently been made available (February 2014) and the local revalidation support team have therefore been unable to fully completed this report. New systems will be implemented to enable the required data collection for the 2015/16 report.

4. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their responsible Officer in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards / executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

- Ensuring that appropriate pre-employment background checks (including pre-employment for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

5. Governance Arrangements

5.1. Trust's Revalidation Team

- Responsible Officer – Dr Nisreen Booya
- Associate Medical Director for Revalidation – Dr Gerard Roney
- Revalidation Manager (Business Manager, Medical Directorate) – Julie Hickling
- Revalidation Administrator (Secretary to the AMD for Revalidation & AMD for Postgraduate Medical Education) – Jenny Spencer
- Revalidation HR Representative – David Batty

5.2. Policy and Guidance Update

The Medical Appraisal Policy was reviewed during April 2014 and is currently progressing through the approval process. The policy review included the inclusion of a Non-Participation Process and Responsible Officer Conflict of Interest or Appearance of Bias. Both documents are based on nationally produced documents. The Remediation Policy that was in draft has been further refined to incorporate a responding to concerns about doctors process. This will shortly be completed. Other guidance/documents written during 2013/14 include 360° Appraisal Guidance and a revision of the Portfolio Minimum Data Set which are available on the Trust's intranet.

6. Medical Appraisal

6.1. Appraisal and Revalidation Data

- Number of doctors as at 31st March 2014 who have a prescribed connection to the Trust:
  Consultants - 89 (4 of which are fixed term)
  SAS and Trust Grades - 60 (4 of which are fixed term)

- Number of completed appraisals:
  Consultants - 84
  SAS and Trust Grades - 57

- Number of doctors in remediation:
  Consultants - 0
  SAS and Trust Grades – 0

- Number of doctors in disciplinary processes:
  Consultants - 0
  SAS and Trust Grades – 0

6.2. Appraisers as at 31st March 2014

- Number of appraisers – 26

- Support activities undertaken:
  - Full day appraiser training was provided on 26th April 2013 and 16th May 2013. All appraisers attended one of the sessions. Both sessions where facilitated by Ms Alys Harwood from RES Consortium. The agenda was drawn up taking account of improvements identified through the reviewing of appraisal documentation during the preceding year.
  - Appraisers Forums were held 18th September 2013 and 29th November 2013. These predominately provided an opportunity for appraisers to share good practice and discuss areas of concern/difficulty.

6.3. Quality Assurance Processes

- The Associate Medical Director for Revalidation reads all submitted appraisals (excluding those where he was appraiser), checking appraisal inputs (appraisal portfolio), appraisal outputs (PDP, appraisal summary and sign-off) and where appropriate requests further work be undertaken prior to AMD recommending to Responsible Officer that annual appraisal is satisfactory. Those appraisals where the AMD was appraiser, the RO reads and checks inputs and outputs.
- Appraisers undertake an annual 360° appraisal in their role as appraisers and this is considered by the AMD and Responsible Officer.
- There is on-going feedback to the doctors being appraised and appraisers, at the time that appraisal submissions are being reviewed. This takes the form of email correspondence or telephone conferences with the relevant doctors. The aim of this is to improve the quality of the appraisal submissions and achieve satisfactory engagement.

6.4. Access, security and confidentiality

- E-appraisal system (MyL2P) is required to be used by all doctors. No breaches to the system or individual portfolios where recorded.

6.5. Clinical Governance

- All doctors are provided with a locked PDF (in-keeping with the advice from an internal audit) record of their Incidents, Complaints, Sickness and Training from the Revalidaiton Team. This data is directly uploaded to the Doctors appraisal record on MyL2P. The minimum requirement for their appraisal portfolio is provided in a Portfolio Minimum Data Set.

7. Revalidation Recommendations (1.4.13 to 31.3.14)

7.1. Number of recommendations - 23
7.2. Recommendation completed on time - 23
7.3. Positive recommendations - 22
7.4. Deferral requests - 1
7.5. Non engagement notifications - 0
7.6. Reasons for missed / late appraisals - no doctors with an imminent revalidation recommendation had a missed or late appraisal

8. Recruitment and engagement background checks

The Trust's pre-employment checks are undertaken on all doctors recruited to the employment of the Trust, the Medical Staffing HR Team undertaking them across the Trust. In addition to the routine checks, a request is made to the doctors current/last Responsible Officer for information about the doctors last appraisal date, whether there are any concerns about the doctors practice, conduct or health and if there are any outstanding investigations. Since January 2014 this request forms part of the conditional offer of employment.

9. Monitoring Performance

The performance of any doctor is monitored in a variety of different ways. It is monitored via the appraisal system which includes a requirement for 360° feedback from service users and colleagues on a three yearly basis and information in relation to whether a doctor is involved in a serious untoward incident or subject to complaint is also included in the appraisal system. The Revalidation Team has been working with the Patient Safety Support Team to improve the linking on Datix of untoward incidents with clinical teams. Serious untoward incidents are investigated using the Trust investigation procedures carried out by the trained investigators. In the event that any concerns are raised these are referred to the Medical Director who can instigate various levels of investigation. A Responding to Concerns and Remediation Policy is in the process of being completed.

10. Responding to Concerns and Remediation

Over the course of the last year a Responding to Concerns Advisory Group has been established. This is chaired by the Responsible Officer/Medical Director and is also attended by the Director of Human Resources and Workforce Development, the Associate Medical Director for Revalidation, Director of Nursing, Clinical Governance and Safety, relevant HR representatives and relevant general management representatives. This is to ensure a consistent and open approach is taken in the investigation of concerns in relation to doctors. This process is described in the Responding to Concerns and Remediation Policy which is currently near completion. Remediation is carried out on an individual basis.

11. Risk and Issues

The implementation of the current appraisal and revalidation system has been at a cost to the Trust. There are increasing demands from NHS England to ensure the quality assurance of the process. This may incur further financial pressures on the Trust.

Over the course of recent years efforts have been made to develop a policy on remediation. This has not been completed to date. It became apparent that the development of a Responding to Concerns process had to be included along with remediation and this is near completion. It is likely that individual remediation will be tailored to the doctors needs and monitored by the Responding to Concerns Advisory Group. It has not been possible to quantify the potential cost of a doctor in difficulty and the associated costs of remediation.

Over the course of recent years the Trust has provided Responsible Officer functions to Barnsley Hospice. This is a potential risk area which remains subject to on-going evaluation.

12. Board Reflections

Over the course of recent years the appraisal/revalidation systems have been developed within the Trust and are becoming more sophisticated. This is in the face of increasing demands from NHS England.

It is the impression of the Revalidation Team that the appraiser training is becoming more sophisticated and recently was designed to allow appraisers to contribute to improving standards. In the course of the last year we have successfully employed the on-line MyL2P system which allows more efficient monitoring and management of appraisal.

The Trust has also taken a lead on the development of a regional revalidation and appraisal network for mental health/community Trusts. This includes Leeds & York, Humber, Rotherham & Doncaster, Sheffield and Bradford. NAVIGO have been invited to the next meeting. This network has been well received and attendance at the meetings is high.

In the course of the coming year the timetabling of appraisals will be changed from the previous system when all appraisals were carried out across summer months to an annualised system. This will be linked with revalidation dates. As a result appraisers will have more time to carry out their role and the revalidation team will be in a better position to monitor completion of appraisals and quality assure submitted documentation.

Work is currently being undertaken to develop in-house training of new appraisers.

13. Corrective Actions, Improvement Plan and Next Steps

- The principle change to the appraisal system which will take place over the next year is the move to an annualised system of appraisal. This will allow better use of resources and enhance quality assurance of the process.
- The revised medical appraisal policy will include a non-engagement policy which will explicitly state to doctors the outcome of failure to engage in the system.
- The Responding to Concerns Advisory Group will be consolidated by the implementation of the appropriate policy.
- Further work will be undertaken to improve the standard of appraisal. This is being initiated through work undertaken in the appraisers training day and will be further developed in the appraisers forum. This will include improving assessment of appraiser contributions and a deselection process where necessary.
- Establish a formal process for sharing of information for a doctor undertaking licensed additional medical practitioners work outside the Trust.
- As referenced in the body of this report, there are increasing demands arising out of the quality assurance requirements which may require additional

administrative support. Consideration will be given to the development of a business case which will be presented at a later date.

14. Recommendations

The Board is asked to accept the report and approve the statement of compliance confirming that the organisation is a designated body as in compliance with the regulations.

APPENDIX 1

AUDIT OF MISSED / INCOMPLETE APPRAISALS

DOCTOR FACTORS	**NUMBER**
Maternity Leave during the majority of the appraisal period	1
Sickness Absence during the majority of the appraisal period	1
Prolonged Leave during the majority of the appraisal period	0
Suspension during the majority of the appraisal period	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio / insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factor (describe)	1 – doctor subject to investigation 1 – bereavement 1 – sickness episode 2 – new starters
APPRAISER FACTORS	**NUMBER**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	1
Lack of time of appraiser	0
Other appraiser factor (describe)	0
ORGANISATION FACTORS	**NUMBER**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

APPENDIX 2

QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.13-31.3.14)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	51	50
Is continuing professional development compliant with GMC requirements?	51	51
Is quality improvement activity compliant with GMC requirements?	51	50
Has a patient feedback exercise been completed?	51	48
Has a colleague feedback exercise been completed?	51	47
Have all complaints been included?	51	51
Have all significant events been included?	51	50
Is there sufficient supporting information from all the doctor's roles and places of work?	51	48
Is the portfolio sufficiently complete for the stage of the revalidation cycle (yr 1 to yr 4)?	51	51
APPRAISAL OUTPUTS		
Appraisal summary	51	50
Appraiser statement	51	51
PDP	51	51

With the exception of one doctor, all of these deficits have been addressed satisfactorily.

APPENDIX 3

AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2013 to 31 March 2014)

Recommendations completed on time (within GMC recommendation window)	23
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	23
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
TOTAL (sum of late and missed)	0

APPENDIX 4

AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)		3		3
Conduct concerns (as primary category)			1	1
Health concerns (as primary category)		1		1
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				1
Consultants (permanent, employed staff)				
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				1
Temporary or short term contract holders				
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.13 and 31.3.14)				1
Number of doctors who have had local restrictions placed on their practice in the last 12 months				4
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.13 and 31.3.14				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.13 and 31.3.14				2
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.13 and 31.3.14+				2
Number of doctors who had their registration / licence suspended by the GMC between 1.4.13 and 31.3.14				0
Number of doctors who were erased from the GMC register between 1.4.13 and 31.3.14				0
NATIONAL CLINICAL ASSESSMENT SERVICES ACTIONS				
Number of doctors about whom NCAS has been contacted between 1.4.13 and 31.3.14				1
Reason for contacts:				
For advice				1
For investigation				0
For assessment				1
Number of NCAS investigations performed				0
Number of NCAS assessments performed				1

APPENDIX 5

AUDIT OF RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

NEW DOCTORS COMMENCING BETWEEN 1.4.13 and 31.3.14	**NUMBER**
Permanent employed doctors	13
Temporary employed doctors	6
Locums brought in to the Trust through a locum agency	24
Locums brought in to the Trust through a 'Staff Bank' arrangements	0
Other (provide explanatory note)	0
TOTAL	43

For how many of these doctors was the following information available within 1 month of the doctor's starting date

	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC / NCAS investigations	DBS	2 recent references	Name of last RO	Reference from last RO	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed	13	13	0	0	13	13	13	*	13	0	13	13	*	*	0
Temporary employed	6	6	1	1	6	6	6	*	6	1	6	6	*	*	1
Locums via locum agency	24	*	0	0	*	24	24	*	24	0	24	24	*	*	0
Locums via staff bank	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	43		1	1	*	43	43	*	43	1	43	43	*	*	1

*Not monitored during 2013/14

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Designated Body Statement of Compliance

The board of South West Yorkshire Partnership NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes, this being the Medical Director Dr N H Booya

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes, this is maintained by the Trust's Medical Revalidation Team utilising GMC Connect and MyL2P

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes, as of 31st March 2014 there are 26 appraisers for 149 doctors with a prescribed connection to the Trust

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Yes, this is achieved by attendance at annual training, appraisers forum (2xpa), undertaking 360° feedback for the role and receiving direct feedback from the AMD for Revalidation on quality issues

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes, see annual report

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Yes, see annual report

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes, existing practices are in place and will be further developed in the Trust's Responding to Concerns Policy

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes, such processes are currently undertaken on an informal basis. With the emergence of this new standard a formal process will be developed

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[1] have qualifications and experience appropriate to the work performed; and

Yes, the Trust's HR procedures are followed

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes, a development plan is in place to continue to improve quality and management of the appraisal and revalidation processes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman]

Date: _ _ _ _ _ _ _ _ _ _

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 7.3(iii)

Title:	**Hard Truths commitments regarding the publishing of staffing data**
Paper prepared by:	Director of Nursing, Clinical Governance & Safety
Purpose:	To advise the Board of the outcome of our staffing review and any action required
Mission/values:	Honest, Open & Transparent, Person First and in the Centre
Any background papers/ previously considered by:	A detailed paper has been considered by Clinical Governance & Clinical Safety Committee.
Executive summary:	**Introduction** The Hard Truths report, the Government response to Francis, requires all NHS Trusts to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust Boards will be required to undertake a detailed review of inpatient staffing using evidence based tools. The first of these is to take place by June 2014 and Trusts are required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. Commissioners will use staffing data as a basis for further questions and discussions with providers. **(Hard Truths, Jan 14)** This paper describes our position in respect of our inpatient staffing review and outlines next steps. In the absence of an evidence based tool for Mental Health (MH) and Learning Disabilities (LD) we have used acuity and safety metrics for our review that we anticipate will be aligned with any future nationally mandated tool. In our general community services we have utilised the Safer Nursing Care Tool (SNCT) which primarily was developed for Acute hospital services but still provides useful analysis. It is important to note that this review coincides with our service transformation plans and shift pattern reviews. Therefore the review provides an important baseline for our ongoing Quality Impact Assessment procedure during this period of change.
Recommendation:	**Trust Board is asked note the contents of the paper, the outcome of the review and the planned action.**
Private session:	Not applicable

Hard Truths Commitments
Regarding the Publishing of Staffing Data

Introduction

NHS Trusts are now required to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing must be published every month; and every six months Trust boards will be required to undertake a detailed review of inpatient staffing using evidence based tools. The first of these must take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. Commissioners will use staffing data as a basis for further questions and discussions with providers. **(Hard Truths, Jan 14)**

Following publication of the Francis report on Mid Staffordshire (Francis 2013), the Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (Keogh 2013) and the Berwick report on improving the safety of patients in England (Berwick 2013), the Department of Health and NHS England asked NICE to develop evidence-based guidelines on safe and effective staffing. The need for guidelines on safe and effective staffing was also highlighted in the recent policy documents and responses: How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013), and Hard Truths, the journey to putting patients first (Department of Health 2013)

Our Response

- In advance of the Hard Truths Commitments, we had initiated a review of current inpatient staffing levels, identifying Skill mix and nurse/patients ratios. This information was triangulated with other key metrics such as incidents / complaints / falls etc. This work showed that there was some variation in approaches and in some instances resulted in further review and investment. It was also clear that further work would be required.

- As a result of this review we initiated a staffing levels project group chaired by the Director of Nursing with the Director of Workforce Development as a key member. The group has three key workstreams:-

    1. Understanding current staffing levels
    2. Determining an evidence based approach to staffing levels (in the absence of an agreed tool for Mental Health)
    3. E-Rostering support to the above (including Board and Ward reporting)

This group has led the staffing review.

Methodology used in reviewing staffing

In the absence of an agreed tool/methodology to support staffing reviews in Mental Health and Learning Disability (MH/LD) wards, we needed to develop a tool to start to capture some of the elements that would indicate demand/acuity. This paper describes our locally determined, evidence based approach The methodology for this involved building upon the paper developed the Nursing Directorate last year which started to identify potential key

indicators. As outlined above, NICE will publish a robust evidence based tool for MH/LD areas, to inform the next staffing exercise in December 2014.

The availability of an accredited acuity tool in adult settings (within our general community services) supported the collection of data in 2 Kendray and 2 Mount Vernon Hospital wards. Staffing levels are set for wards based on the layout of the ward, patient acuity, bed occupancy, advice from the Royal Colleges. This is not an exact science, and clinical judgment is used, supported by acuity scoring, ward performance measures and effectiveness of off duty planning.

The Safer Nursing Care Tool (SNCT), which is based on a set of nationally agreed Acuity measures, was implemented across the 4 wards between 7th May and 3rd June 2014 and outcomes are reported upon below. The SNCT is a recognised evidence based tool, used to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity and dependency terms. This tool has been further endorsed by the Shelford Group (2012) who reviewed the tool, its definitions and multipliers to ensure it remains current and applicable. The multipliers in the tool allow for a 22% uplift for annual leave / study leave. This Safer Nursing Care Tool is currently acknowledged to be widely used with the NHS and is advocated within the Chief Nursing Officers guidelines on staffing. The "Safer Nursing Care Tool" also pulls in the results of nurse sensitivity indicators such as patient falls and pressure ulcers.

Within MH/LD ward areas, the tool we have developed looks at a set of metrics and indicators that should tell us if any of the areas are significant outliers. Also, they start to build up a picture which can be compared and contrasted with similar areas. Because the wards vary widely in terms of size, acuity, care group etc, caution needs to be exercised about making direct comparisons. It is anticipated that, whilst we await guidance from NICE, if the current tool is developed, wards will be able to contrast and compare their metrics and indicators against their previous ones, giving potential acuity measures. From there we have the opportunity to consider if the staffing levels and/or skill mix required review.

A more detailed explanation of the metrics/KPI's is in included in Appendix 1.

This report has been collated and developed using current workforce data at March 14, (staffing establishments, skill mix, e-rostering templates for each ward), and by interpreting the Trust's Incident Management System (Datixweb). Activity data for 13/14 period is also utilised. Figures from Datixweb are based on the 12 month period from April 2013 to March 2014. An analysis of the data was undertaken by staff in the Nursing Directorate which has generated some further Key Lines of Enquiry.

In order to determine staffing ratio's etc, MH/LD wards were assumed to be running on 100% bed occupancy. For staffing ratio's to be made more "live" they will need to be calculated in real time – ie, staff per occupied bed rather than total beds which is much more complex. To accurately collect some of the more relevant and sophisticated metrics (e.g. one to one observations, escorts etc) will require frontline staff to collect real time data – time that is spent away from direct patient care (Hurst 2010). It is likely that any tools developed by NICE in the future will require a degree of "real time" data collection by frontline staff and this is likely to be on an ongoing basis.

The difficulty of measuring staffing levels consistently across a four shift system is considerable. For this reason staffing levels are measured taken at the lowest numbers rota'd on days and on nights. Ratio's on the peak Monday – Friday 9-5 period may be higher in many units. Also as figures in this report are based on 100% occupancy, units with a lower occupancy rate will have higher staffing ratios.

Analysis

For the purposes of analysis the wards are broken down into care groups. This does not mean that they can be compared exactly "like for like", but it does make it easier to see outcomes in areas with a similar service user population.

The groups are.

1. **AWA Acute wards** – Ashdale, Elmdale, Ward 18, Priory, Trinity, Clark, Beamshaw
2. **PICU's** – Trinity 1, Melton Suite
3. **Rehab and Recovery** – Lyndhurst, Enfield Down, Castle Lodge, Saville Park View,
4. **OPS** – Beechdale, Ward 19, Chantry, Willow
5. **OPS community residential** – Poplars,
6. **Learning Disability Units** – Foxview, Horizon
7. **Forensic** – Appleton, Bronte, Chippendale, Gaskell/Johnson, Hepworth, Priestley, Waterton
8. **Low secure (Bretton)** – Almondbury, Thornhill, Sandal, Ryburn
9. **Learning Disability low secure** - Newhaven
10. **Substance Misuse Unit** – SMU Barnsley
11. **Adult Acute Wards –** MVH ward 4, Ward 5, SRU, NRU

Selected Datix fields for the period April 2013 – March 2014, as well as other Acuity measures supplied by Performance and Information were added to the spreadsheet to enrich the data set. Information was collated into spreadsheets (see appendix 2). Wards were clustered broadly by care group (they are not always an exact match). From the available data this was accurate at 31 Mar 14.

Within appendix 2, in addition to Registered Nurse / Service User (RN's/SU) figures, total staff to SU figures are also given.

Some key findings - MH/LD areas

- The skill mix and numbers of RN's per bed varied across the units.
- Highest levels were typically seen in AWA, PICU and Forensic areas, with lowest typically in OPS and rehab and recovery areas - but not all areas followed this pattern.
- Staff/patient ratio's also varied but the distinction between wards in the same care groups (with some exceptions) was less evident and, perhaps as expected, smaller units tended to have higher ratios.
- In 2013/14, 125 incidents related to staffing were recorded on Datixweb, an average of one every 3 days. Forensic services were particularly high reporters of staffing

issues with Bronte, Thornhill and Sandal wards, the 3 highest in the Trust. Broadly speaking the vast majority of incidents fell into one of the categories below. All of these incidents were reviewed and confirmed by managers.

- Staff sickness / absence and unable to secure bank / agency staff at short notice
- Unexpected clinical demand
- Insufficient skill mix to undertake specific tasks

Recent guidance published by NICE for Adult Acute wards suggests the ratio of RN's/SU should be 8:1. It is difficult to obtain data to utilise that provides comparable benchmarks, but anecdotally, many trusts were reported to be not compliant with this ratio across all ward areas. Averages for SWYPFT wards by care group are provided within appendix 3.

The review undertaken by Senior Nurses and Practice Governance Coaches in the directorate considered whether any area(s) were significant outliers in respect of any of the fields and this has generated a number of key lines of enquiry that have required further examination.

Some key findings – Adult ward areas

The SNCT was commenced on 7th May 2014 and completed on 3rd June 2014. Using the recommended multipliers the findings are as follows:

7th May to 3rd June 2014					
Ward	**No. of days SNCT data collected**	**No. of beds**	**SNCT May/June 2014**	**Establishment excluding ward manager**	**Occupancy**
4	20	24	34.31	34.08	87.5%
5	20	24	36.85	34.08	100%
SRU	20	16	26.8	28.8	93.75%
NRU	20	12	16.21	21.88	75%

Our funded establishment allow for SNCT suggested ratio on the majority of day time shifts however, should an area have any long term absence or vacancy there is potential that the staffing ratio will not be met, resulting in a high reliance on additional hours and occasionally use of overtime bank. There is no suggested level set for night time shifts in the tool but the evidence base suggests less favourable outcomes the lower the registered nurse:patient ratio.

On average ratio is shown in Appendix 1. Please note we tend to have a lower ratio of registered nurses to nursing support staff, but clinically there is a preference to have more nursing support workers due to the reliance of patients on nursing staff and this does not create any supervision issues.

Summary MH/LD areas

As highlighted already, the area of this report concerning MH/LD areas was developed in the absence of an agreed accredited tool to measure acuity and staffing.

The collation of planned v actual staffing levels (which is another Hard Truths workstream), will start to inform in greater detail just how accurate and how often wards are able to maintain planned staffing levels. This may allow more detailed interpretation of the data and should continue to increase the accuracy. It should also be noted that the organisation is

undergoing significant reviews of shift patterns and headroom and will require consideration of how they impact upon this agenda.

If wards are fully staffed up to their budgeted establishment and e-rosters are fulfilled as planned, the vast majority are better than 1:8 RN's/SU for weekday shifts (early, 9-5, middle shifts). The averages for units in same areas of the care pathway is included at appendix 3. Where this isn't achieved it is usually weekend and night shifts, and tends to be areas with lower levels of acuity. Where total staff/SU ratio's are considered all wards are comfortably lower than 1:8.

Where establishments are realised, rota's numbers are met, and there is no unusual or extraordinary levels of unplanned work, current establishments should be able to provide a safe and effective standard of care.

Should rota'd staffing levels fall below what is agreed or should clinical demand increase dramatically, clinical risk may increase in a way that is disproportionate to staffing required to manage it. At these times, effective escalation and use of bank or other sources of securing additional staffing are the key mitigating factors to keeping staffing levels safe and effective. All areas have processes and arrangements in place to escalate concerns and to access additional staffing from the staff bank.

None of our CQC visits, both compliance or Mental Health Act has raised any significant concerns in relation to staffing within SWYPFT.

Summary Adult ward areas

Current staffing levels have been monitored over the last month using the evidence based SNCT and the budgeted establishment on the majority of wards matched the acuity of patients. All wards currently allow the staffing ratio of 1 registered nurse to no more than 8 patients on a day time shift. Our wards may not meet this requirement in the presence of long term sickness and vacancies. There is no suggested ratio for night time registered nurse levels recommendation at this time.

With the exception of the neurological rehabilitation unit, those trained levels of staff are almost always met. The neurological rehabilitation unit however, often cannot fill 2 trained staff on late shifts and on occasion the Stroke Rehabilitation Unit cannot fill 3 trained on earlies.

Factors influencing this are that wards are on 2 sites and for health and safety, breaks and covering sickness an additional trained nurse works on nights in both areas (within budget).

Next Steps

The review provides an important baseline for future benchmarking during a time of change. In order the ensure that we continue to monitor and review ward staffing levels using this data the following actions are required.

- Review planned v actual staffing level data on a monthly basis using the new planned versus actual report. A copy of the first report is enclosed at Appendix 4 – from June 14
- Further develop evidence based tool to review in patient staffing levels, ensuring alignment with possible national guidance to be issued later this year – Action by Dec 14
- Finalise investigation into defined key lines of enquiry and take action as required – Action by Sept 14.
- Provide regular updates to the Clinical Governance & Clinical Safety Committee.

- **Appendix 1**

How the metrics/KPI's were calculated

Workforce/skill mix measures

Roster templates were supplied by HR workforce which gave e-rosters for each ward as well as figures for budgeted establishment, staff in post and "demand". Figures used in calculations are based on budgeted establishment. Skill mix (RN/HCA %) figures are also supplied by HR workforce.

Registered nurses per bed is calculated by dividing the number of beds available on the unit by the number of registered nurses in the establishment. A second figure is given with ward manager extracted (this is a recommendation within Hard Truths).

The lowest SU to RN ratio is calculated upon 100% bed occupancy divided by the lowest numbers of RN's on an early or late shift. These were typically at weekend. Same calculation repeated in relation to nights. Total staff per SU ratio was based on lowest total numbers of staff (RN's and HCA's) on an early or late shift. Repeated for nights.

Acuity indicators

The total admissions in a 12 month period is shown as is the number of those that were formal. From this the average number of admissions per month and per bed is calculated. The ratio of formal admissions against the overall total is given as a percentage (it would have been helpful to have further detail on the numbers of individuals subsequently made subject to the MHA after an informal admission but these figures not readily available).

Quality metrics

The numbers of formal informal concerns (complaints) raised as well as compliments. The numbers of incidents which had "staffing issues" as a category.

The number of Serious Incidents's recorded via Datixweb (amber or red) was divided by the number of beds to give a prevalence score, as was the numbers of incidents of violence against staff and the numbers of (only nursing specific/attributable) medication errors. In older people's services, the same formula is applied to slips, trips and falls.

Adult Rehab Wards – MVH Ward 4, Ward 5, NRU, SRU (Kendray)

For the purposes of analysis the wards included are listed below. It should be noted that the wards cannot be compared as "like for like", but it does make it easier to see outcomes in areas with a similar service user population.

The wards are.

- Mount Vernon Hospital – Ward 4
- Mount Vernon Hospital – Ward 5
- Kendray Hospital – Stroke Unit (SRU)
- Kendray Hospital – Neurological rehabilitation Unit (NRU)

Current Position

- Ward 4 24 predominantly older patients
- Ward 5 24 predominantly older patients
- Stroke Unit 16 patients (18+ years) stroke rehabilitation
- NRU 12 patients (18+ years) neurological rehabilitation

Funded Staffing Establishment

Unit	**Grade**	**WTE Current**
Ward 4	HCA/RA	19.48
	RN	14.6
Ward 5	HCA/RA	19.48
	RN	14.6
SRU	RN	13.6
	HCA/RA	15.2
NRU	RN	9.5
	HCA/RA	12.3

Skill Mix Ratio

On average on Wards 4 and 5 currently 43:57 – trained and untrained
On average in SRU currently 47:53 – trained and untrained
On average in NRU currently 44:56 – trained and untrained

Rotas for each ward are Early, Late and Nights and have the following staff coverage wherever possible:

WARD	**TRAINED**	**UNTRAINED**
Wards 4 & 5	3 trained on Early	4 untrained on Early
	2 trained on Late	3 untrained on Late
	1 trained on Nights	2 untrained on Nights
SRU	3 trained on Early	3 untrained on Early
	2 trained on Late	3 untrained on Late
	1 trained on Nights	1 untrained on Nights
NRU	2 trained on Early	3 untrained on Early
	2 trained on Late	3 untrained on Late
	1 trained on Nights	1 untrained on Nights

Staffing levels are set for adult wards based on the layout of the ward, patient acuity, bed occupancy and advice from the Royal College. This is not an exact science and clinical judgement is used supported by acuity scoring, ward performance measures and effectiveness of off duty planning.

The Francis Enquiry advocates that providing ward managers with supernumerary status facilitates improved leadership and quality. At MVH and SRU/NRU the baseline establishment recognises the important of this requirement, and the Ward Managers are

identified as supernumerary on the off duty. This complies with Expectation 6 of the Chief Nursing Officers Guidelines – ensuring staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Staffing levels were set 5 years ago following reorganisation of services at Mount Vernon Hospital and development of Intermediate Care provision. Levels for wards 4 & 5 were set on a local basis, following RCN guidelines for care of older people recommendations in hospital settings. Allowance was made for annual leave, training and sickness.

For the stroke unit, staffing levels were determined by RCP clinical guidelines for stroke patients.

For the neurological rehabilitation unit, staffing levels were already set when the unit was taken over from learning disability services 7 years ago. Adjustments have been made over this period due to the changing nature of patient acuity within the unit.

Appendix 2

Barnsley BDU

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

														Datix				
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio	SU per RN nights ratio	Total staff ratio am or pm ratio	Total staff ratio nights	Total Admissions	Average Admissions per Month	Admissions Per Bed	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Ward 4	24	34.08	43:57	0.61	0.57	1:8	1:16	1.3.4	1:8	224	18.67	9.33	3	27	Not available	0.08 (2 amber)	0.16 (4)	0.54 (13)
Ward 5	24	34.08	43:57	0.61	0.57	1:8	1:16	1:3.4	1:8	230	19.17	9.58	0	7	Not available	0.04 (1 amber)	0.16 (4)	1 (24)
SRU	16	28.8	47:53	0.85	0.78	1:6	1:9.3	1:4.1	1:9.3	155	12.92	9.69	2	21	Not available	None	0.18 (3)	0.18 (3)
NRU	12	21.88	44:56	0.79	0.71	1:6	1:9.3	1:3	1:9.3	121	10.08	10.08	0	0	Not available	None	0.42 (5)	0.42 (5)

AWA Acute Wards

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

	Workforce									Acuity						Datix				
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Ashdale	24	37.34	52/48	0.80	0.76	12:1	12:1	4.8:1	6:1	325	89	27.08	13.54	27%	11	2	5	0.33 (8)	0.25 (6)	0.20 (5)
Elmdale	24	41.02	60/40	1.02	0.98	8:1	8:1	4:1	4:1	325	87	27.08	13.5	27%	7	4	7	0.16 (4)	0.29 (7)	0.75 (18)
Ward 18	23	42.93	54/46	0.91	0.86	7.6:1	11.5:1	3.8:1	5.75:1	233	78	19.42	10.13	33%	10	2		0.04 (1)	0.30 (7)	0.91 (21)
Priory 2	22	32.70	57/43	0.78	0.73	7.3:1	11:1	4.4:1	5.5:1	244	75	20.33	11.09	31%	14	1	5	0.13 (3)	0.27 (6)	0.63 (14)
Trinity 2	22	31.83	57/43	0.80	0.75	11:1	11:1	5.5:1	5.5:1	229	71	19.08	10.41	31%	8	20	1	0.18 (4)	0.40 (9)	0.95 (21)
Kendray Beamshaw	14	34.35	40/60	0.94	0.87	7:1	7:1	2.8:1	2.8:1	130	72	10.83	9.29	55%	7	5	7		0.28 (4)	0.64 (9)
Kendray Clark	14	35.85	43/57	0.94	0.87	7:1	7:1	2.8:1	3.5:1	120	61	10.00	8.57	51%	6		2	0.07 (1)		0.42 (6)

PICU

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																Datix				
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Trinity 1 (Inc 136)	13	47.15	55/45	1.98	1.90	4.3:1	6.5:1	1.8:1	2.6:1	62	57	5.17	4.77	92%			8	0.46 (6)	2.46 (32)	1.38 (18)
Kendray PICU	6	24.55	42/58	2.0	1.8	3:1	6:1	1.5:1	2.:1	14	14	1.17	2.33	100%	3	1	3	0.83 (5)	0.33 (2)	1.16 (7)

Rehab & Recovery

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

														Datix							
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)	Slips, Trips and Falls Per bed (OPS only)
Lyndhurst	14	24.62	36/64	0.77	0.70	14:1	14:1	3.5:1	4.6:1	2		0.17	0.14	0%	1		1	0.21 (3)	0.14 (2)	0.21 (3)	
Enfield Down	31	50.18	38/62	0.50	0.47	15.5:1	15.5:1	5.1:1	6.2:1	61	3	5.08	1.97	5%		1		0.09 (3)	0.03 (1)	0.54 (17)	
Castle Lodge	14	25.40	48/52	0.74	0.67	7:1	14:1	3.5:1	4.6:1	10	3	0.83	0.71	30%			2	0.07 (1)	0.14 (2)	0.28 (4)	
Saville Park View	10	23.09	39/61	1.0	0.95	10:1	10:1	3.3:1	3.3:1	48	1	4.00	4.8	2%	2	1		0.2 (2)		0.4 (4)	4.7 (47)

OPS

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

															Datix					
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)	Slips, Trips and Falls Per bed (OPS only)
Beechdale	16	26.90	51/49	0.82	0.75	8:1	16:1	4:1	5.3:1	108	26	9.00	6.75	24%	4	6	7	0.12 (2)		1.25 (20)	7.5 (120)
Ward 19	30	47.91	58/42	0.64	0.61	5:1	7.5:1	3:1	3.75:1	174	40	14.50	5.8	23%	2	22	5	0.16 (5)	0.06 (2)	0.43 (13)	5.6 (168)
Chantry	16	30.18	36/64	0.97	0.91	8:1	8:1	4:1	4:1	122	38	10.17	7.63	31%	3	1		0.25 (4)	0.37 (6)	0.18 (3)	3.6 (58)
Willow Ward	10	26.40	43/57	1.10	1.0	5:1	10:1	2.5:1	3.3:1	23	12	1.92	2.3	52%		1		0.1 (1)		0.2 (2)	

OPS Community Residential

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																	Datix				
	Beds	Budgeted staff	Skill Mix (supplied by workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents Amber & Red per bed (Total)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)	Slips, Trips and Falls Per bed (OPS only)
The Poplars CUE	15	25.56	30/70	0.78	0.72	15:1	15:1	3.75:1	5:1	24	6	2.00	1.6	25%	1	7	1	0.06 (1)		0.4 (6)	7.8 (117)

Learning Disability Units

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																	Datix			
	Beds	Budgeted staff	Skill Mix (supplied by workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Fox View	5	13.38	60/40	1.53	1.33	5:1	5:1	1.6:1	2.5:1	48	3	4.00	9.6	6%		2		0.2 (1)	0.2 (1)	
Horizon Centre	4	19.67	37/63	2.1	1.85	4:1	4:1	1.3:1	1.3:1	21	10	1.75	5.25	48%	1	1	3	1.5 (6)	6.25 (25)	0.75 (3)

Forensic

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																Datix			
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Appleton	7	26.66	59/41	1.86	1.72	3.5:1	3.5:1	1.75:1	2.3:1	5	5	0.42	0.71	100%				0.14 (1)	0.71 (5)	1.28 (9)
Bronte	8	25.00	50/50	1.62	1.50	4:1	4:1	2:1	2:1	12	12	1.0	1.5	100%	1		17	0.62 (5)	0.5 (4)	0.75 (6)
Chippendale	13	27.70	59/41	0.98	0.90	6.5:1	6.5:1	3.25:1	4.33:1						3		8	0.07 (1)	0.07 (1)	0.15 (2)
Gaskell	0									0	2	2	0.17							
Johnson	15	32.40	43/57	1.1	0.97	7.5:1	7.5:1	3.75:1	3.75:1	1	1	0.2	0.2	100%	1					0.4 (6)
Hepworth	14	32.60	56/44	1.21	1.1	7:1	7:1	3.5:1	3.5:1	16	16	1.33	1.14	100%	6		6	0.14 (2)	0.28 (4)	0.35 (5)
Priestley	17	28.60	56/44	0.76	0.7	8.5:1	8.5:1	5.6:1	5.6:1							2				0.05 (1)
Waterton	16	25.85	56/44	0.86	0.80	8:1	8:1	4:1	5.3:1									0.06 (1)		0.5 (8)

Low Secure (Bretton)

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																Datix			
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Almondbury	10	22.23	?	0.96	0.86	10:1	10:1	3.3:1	3.3:1								4			0.2 (2)
Thornhill	15	23.13	50/50	0.77	0.70	15:1	15:1	5:1	5:1	6	5	0.50	0.4	83%	2		12	0.06 (1)	0.4 (6)	0.6 (9)
Sandal	6	19.20			1.3	6:1	6:1	2:1	2:1	7	7	0.58	1.17	100%			14	0.16 (1)	1.16 (7)	1.0 (6)
Ryburn	7	12.80	50/50		0.97	7:1	7:1	3.5:1	3.5:1								3			0.85 (6)

Learning Disability Low Secure

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																	Datix			
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Newhaven	16	37.34	41/59	1.0	0.93	8:1	8:1	2.6:1	4:1	1	1	0.08	0.06	100%	1	1	4		0.18 (3)	0.56 (9)

Substance Misuse Unit

Beds Numbers / Datix Incidents April 2013 - March 2014 / Skill Mix

																Datix				
	Beds	Budgeted staff	Skill Mix (supplied by HR workforce)	RN/Bed (inc ward manager)	RN per bed (excl ward manager)	SU per RN am or pm ratio (lowest)	SU per RN nights ratio (lowest)	Total staff ratio am or pm ratio (lowest)	Total staff ratio nights (lowest)	Total Admissions	Formal Admissions	Average Admissions per Month	Admissions Per Bed	% of formal on admission	Formal / Informal Concerns	Compliments	Staffing Issues Recorded on Datix	Serious Incidents (Amber & Red per bed)	VAS Incidents Yellow & above Apr 13 - Mar 14 Per bed (Total)	Medication Errors (Per Bed)
Kendray Ward SMU	8	21.60	43/57	1.12	1.05	8:1	8:1	2.6:1	4:1	91		7.58	11.38	0%		40				0.5 (4)

Appendix 3

These figures are predicated on 100% bed occupancy and are the average of the lowest staffing ratio's during early / late shifts (including weekend) and night shifts.

AWA ACUTE WARDS (Ashdale, Elmdale, Ward 18, Priory 2, Trinity 2, Beamshaw, Clark)

Shift (s)	**Ratio SU/RN (average)**	**Range**
Early and Late (inc weekends)	8.55:1	7-12
Night	9.6:1	7-12
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	4:1	2.8 – 5.5
Night	4.72:1	2.8 – 6.1

PICU (Trinity 1 and Kendray)

Shift (s)	**Ratio SU/RN (average)**	**Range**
Early and Late (inc weekends)	3.65:1	3.1 – 4.3
Night	6.25:1	6.0 – 6.5
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	1.65:1	1.5 – 1.8
Night	2.3:1	2.0 – 2.6

REHAB AND RECOVERY (Lyndhurst, Enfield Down, Castle Lodge, Savile Park View)

Shift (s)	**Ratio SU/RN (average)**	**Range**
Early and Late (inc weekends)	11.62:1	7.1 – 15.5
Night	13.37:1	14 – 15.5
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	3.85:1	3.5 – 5.1
Night	4.67:1	4.6 – 6.2

OLDER PEOPLES WARDS (Beechdale, Ward 19, Chantry, Willow Ward)

Shift (s)	**Ratio SU/RN (average)**	**Range**
Early and Late (inc weekends)	6.5:1	5.1 – 10.1
Night	12.37:1	7.5:1 – 16.1
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	3.37:1	2.5 – 4.1
Night	4.08:1	3.3 – 5.3

OLDER PEOPLES COMMUNITY UNIT (Poplars)

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	15:1	N/A
Night	15:1	N/A
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	3.75:1	N/A
Night	5:1	N/A

LD (Fox View and Horizon)

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	4.5:1	4 - 5
Night	4.5:1	4 - 5
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	1.45:1	1.3 – 1.6
Night	1.9:1	1.3 – 2.5

FORENSICS (MEDIUM SECURE) (Appleton, Bronte, Chippendale, Gaskell, Johnson, Hepworth, Priestley, Waterton)

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	6.42:1	3.5 – 8.5
Night	6.42:1	3.5 – 8.5
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	3.42:1	1.75 – 5.6
Night	3.65:1	2 – 5.6

FORENSIC (LOW SECURE) (Almondbury, Thornhill, Sandal, Ryburn)

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	9.5:1	6 – 15
Night	9.5:1	6 – 15
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	3.45:1	2 – 5.1
Night	3.45:1	2 – 5.1

FORENSIC (LOW SECURE) (Newhaven)

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	8:1	N/A
Night	8:1	N/A
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	2.6:1	N/A
Night	4:1	N/A

SUBSTANCE MISUSE UNIT

Shift (s)	Ratio SU/RN (average)	Range
Early and Late (inc weekends)	8:1	N/A
Night	8:1	N/A
Shift (s)	**Ratio SU/Total staff (average)**	**Range**
Early and Late (inc weekends)	2.6:1	N/A
Night	4:1	N/A

Adult wards

WARD 4

Shift (s)	Ratio of Registered Nurses per Service User (average)
Early and Late (inc weekends)	1:8
Night	1:16
Shift (s)	**Ratio of total staff per Service User (average)**
Early and Late (inc weekends)	1:3.4
Night	1:8

WARD 5

Shift (s)	Ratio of Registered Nurses per Service User (average)
Early and Late (inc weekends)	1:8
Night	1:16
Shift (s)	**Ratio of total staff per Service User (average)**
Early and Late (inc weekends)	1:3.4
Night	1:8

NRU

Shift (s)	Ratio of Registered Nurses per Service User (average)
Early and Late (inc weekends)	1:6
Night	1:6
Shift (s)	**Ratio of total staff per Service User (average)**
Early and Late (inc weekends)	1:2
Night	1:9.3

SRU

Shift (s)	Ratio of Registered Nurses per Service User (average)
Early and Late (inc weekends)	1:8
Night	1:9.3
Shift (s)	**Ratio of total staff per Service User (average)**
Early and Late (inc weekends)	1:4.1
Night	1:9.3

Appendix 4

South West Yorkshire Partnership NHS Foundation Trust

	Day				Night							
	Registered nurses		Care Staff		Registered nurses		Care Staff		Day		Night	
Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
FIELDHEAD HOSPITAL	18,360.0	17,299.7	18,752.7	20,470.3	9,196.0	8,211.4	8,916.5	11,846.6	94.2%	109.2%	89.3%	132.9%
CASTLEFORD & NORMANTON DISTRICT HOSPITAL	501.6	688.3	930.0	819.6	290.5	291.6	580.6	434.3	137.2%	88.1%	100.4%	74.8%
THE POPLARS	591.6	809.9	1,490.8	1,576.1	290.5	290.5	580.6	655.6	136.9%	105.7%	100.0%	112.9%
ENFIELD DOWN	1,259.8	1,247.9	2,160.8	1,760.6	651.0	651.0	976.5	979.0	99.1%	81.5%	100.0%	100.3%
THE DALES	4,618.0	3,700.2	3,310.0	3,791.3	1,901.2	1,788.9	2,211.2	2,361.5	80.1%	114.5%	94.1%	106.8%
LYNDHURST	495.0	843.3	1,442.5	872.5	310.0	345.8	620.0	640.0	170.4%	60.5%	111.5%	103.2%
KENDRAY HOSPITAL	6,356.8	5,969.2	8,025.8	9,132.1	3,395.3	3,421.8	4,083.5	5,379.0	93.9%	113.8%	100.8%	131.7%
MOUNT VERNON HOSPITAL	2,790.0	2,318.5	2,790.0	3,625.8	999.8	999.8	1,333.0	1,333.0	83.1%	130.0%	100.0%	100.0%
PRIESTLEY UNIT	4,457.5	3,848.9	3,555.1	4,038.7	1,680.4	1,703.9	2,003.0	2,635.3	86.3%	113.6%	101.4%	131.6%

Actual and Planned Staffing Hours: May 2014

Ward Name	Day				Night				Day		Night		
	Registered nurses		Health Care Assistants		Registered nurses		Health Care Assistants						
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)	Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)	**Average Fill Rate - All Staff (%)**
Appleton	1,089	972	925	844	597	375	299	520	89.3%	91.2%	62.9%	174.3%	**93.2%**
Ash Dale	1,501	1,217	1,393	1,127	661	640	661	715	81.1%	80.9%	96.8%	108.1%	**87.7%**
Beamshaw	930	962	1,392	1,594	667	590	1,000	1,311	103.5%	114.5%	88.5%	131.1%	**111.8%**
Beechdale	1,157	924	930	1,415	310	311	620	751	79.9%	152.1%	100.3%	121.1%	**112.7%**
Bretton Centre	2,726	2,494	2,963	3,570	1,195	1,260	2,091	2,430	91.5%	120.5%	105.5%	116.2%	**108.7%**
Bronte	991	1,058	1,022	1,646	597	646	597	859	106.8%	161.2%	108.2%	143.8%	**131.3%**
Castle Lodge	930	732	930	1,110	306	306	612	612	78.7%	119.4%	100.0%	100.0%	**99.3%**
Chantry Unit	795	803	1,357	1,564	290	291	581	590	100.9%	115.3%	100.0%	101.6%	**107.4%**
Chippendale	1,071	816	915	985	597	386	299	501	76.2%	107.7%	64.6%	167.8%	**93.3%**
Clark	928	896	1,395	1,384	667	656	667	773	96.5%	99.2%	98.4%	115.9%	**101.4%**
Elmdale	1,960	1,559	987	1,250	930	838	930	896	79.5%	126.6%	90.1%	96.3%	**94.5%**
Enfield Down	1,260	1,248	2,161	1,761	651	651	977	979	99.1%	81.5%	100.0%	100.3%	**91.9%**
Fox View	574	586	316	798	341	330	342	342	102.1%	252.9%	96.8%	100.0%	**130.8%**
Hepworth	1,411	1,190	1,058	1,136	597	600	597	585	84.3%	107.3%	100.4%	97.9%	**95.8%**
Horizon	494	455	1,053	1,510	310	303	310	955	92.3%	143.4%	97.8%	308.1%	**148.8%**
Lyndhurst	495	843	1,443	873	310	346	620	640	170.4%	60.5%	111.5%	103.2%	**94.2%**
Neuro Rehab Unit	930	688	930	1,279	540	540	158	214	74.0%	137.5%	100.0%	135.7%	**106.4%**
Newhaven	1,088	1,070	1,838	1,632	597	597	596	594	98.3%	88.8%	100.0%	99.7%	**94.5%**
PICU	848	714	960	1,182	372	465	744	1,049	84.3%	123.1%	124.9%	140.9%	**116.6%**
Poplars	592	810	1,491	1,576	290	290	581	656	136.9%	105.7%	100.0%	112.9%	**112.8%**
Priestley	924	864	858	841	597	318	299	578	93.5%	98.1%	53.2%	193.6%	**97.1%**
Priory 2	1,394	1,507	925	807	581	581	581	583	108.1%	87.2%	100.1%	100.3%	**99.9%**
Savile Park	502	688	930	820	290	292	581	434	137.2%	88.1%	100.4%	74.8%	**97.0%**
Stroke Rehab Unit	1,163	1,058	1,395	1,434	484	484	516	538	91.0%	102.8%	100.0%	104.2%	**98.7%**
Substance Misuse Unit	630	635	1,028	1,060	333	349	333	349	100.7%	103.2%	104.7%	104.7%	**102.9%**
Trinity 1	1,836	1,631	1,832	1,828	1,155	869	581	1,058	88.9%	99.8%	75.2%	182.2%	**99.7%**
Trinity 2	1,201	1,176	923	991	581	581	581	602	97.9%	107.3%	100.0%	103.6%	**102.0%**
Ward 18	1,577	1,388	1,386	1,219	664	665	664	825	88.0%	88.0%	100.0%	124.2%	**95.4%**
Ward 19	2,306	1,875	1,854	2,022	675	709	997	1,468	81.3%	109.1%	105.1%	147.3%	**104.2%**
Ward 4	1,395	1,147	1,395	1,793	473	473	667	667	82.2%	128.5%	100.0%	100.0%	**103.8%**
Ward 5	1,395	1,172	1,395	1,833	527	527	667	667	84.0%	131.4%	100.0%	100.0%	**105.4%**
Waterton	993	1,096	1,025	658	597	423	299	462	110.4%	64.2%	70.8%	154.9%	**90.6%**
Willow Ward	929	1,017	926	1,200	333	339	667	1,147	109.6%	129.5%	101.7%	172.1%	**129.7%**
Women's Service	1,418	1,436	1,129	1,348	597	675	596	916	101.2%	119.4%	112.9%	153.8%	**116.9%**
All Wards	39,430	36,726	42,458	46,087	18,715	17,705	21,305	26,264	90.8%	106.6%	91.2%	117.3%	**104.0%**

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 8

Title:	**Trust Board self-certification – Corporate Governance Statement, certification on AHSCs and governance, and training of governors**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to make the required self-certifications as part of the governance statements required to inform the five-year strategic plan.
Mission/values:	The Trust's five-year strategic plan will describe how the Trust will meet its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received the two-year operational plan 25 March 2014 (submitted to Monitor on 4 April 2014); the independent report on the plan 29 April 2014; and a paper on compliance with the Trust's licence on 25 March 2014. Trust Board also made a self-certification on 20 May 2014 in relation to systems for compliance with licence conditions and availability of resources.
Executive summary:	Background As part of the annual planning arrangements, Monitor requires the Trust to make a number of governance statements under its licence conditions, the Risk Assessment Framework and the Health and Social Care Act 2012. For the two-year operational plan submission, there was no requirement for Trust Board to make a self-certification; however, as part of the five-year strategic plan, Trust Board is required to make self-certifications in relation to: 1. systems for compliance with licence conditions (general condition 6 of the NHS Provider Licence); 2. availability of resources (continuity of services condition 7 of the NHS Provider Licence); 3. Corporate Governance Statement (Risk Assessment Framework); 4. any major joint venture or Academic Health Science Centre or where Boards are considering entering into either (appendix E of the Risk Assessment Framework); and 5. training of governors (s151(5) of the Health and Social Care Act 2012). Self-certifications against items 1 and 2 were made by Trust Board on 20 May 2014 and submitted to Monitor by the required date of 30 May 2014. Items 3 and 5 are required by 30 June 2014 and are the subject of this paper. Item 4 is not applicable to this Trust at the current time. Corporate Governance Statement The attached paper sets out the statements Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is advised that it is able to make the required self-certification in relation to the Trust's Corporate Governance Statement. Training of governors Trust Board is required to declare that it is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

	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 supports the training and development of governors in a number of ways. - There is an annual session to evaluate the contribution and work of the Members' Council, facilitated by an external facilitator and includes a self-assessment by governors, both individually and collectively, of their contribution and effectiveness. New members also participate in the annual evaluation of Members' Council activity, which enables them to learn from the experience of others. - The Trust offers 1:1 support and 'buddying' as part of the induction programme for Governors. - Attendance at national GovernWell training modules is also encouraged and the Trust facilitates attendance. - Each governor has an induction meeting with the Chair and a review meeting to discuss individual performance and training and development needs. - The Trust arranges briefing sessions for governors in areas identified where it is felt more in-depth and detailed knowledge would be beneficial. This includes finance and performance, and Trust services. The Members' Council has generally signed up to the principle that there should be a level of minimum commitment and contribution from governors at two levels. <u>Required</u> - Attendance at a minimum of three out of four formal Members' Council meetings. - Attendance at the annual evaluation session. - 1:1 introductory meeting with the Chair. - Annual review meeting with the Chair. - Attendance at the annual members' meeting. <u>Desirable</u> - Attendance at the Foundation Trust Network's GovernWell modules. The Trust will encourage all governors to attend the core skills module in their first year of office. - Attendance at Trust Board meetings. It was suggested that all governors should attend at least one meeting. - Attendance at Trust dialogue groups (for publicly elected governors). - Attendance at training and development sessions organised by the Trust. This would cover finance and performance, and significant transactions as regular sessions. - Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee). From the assurance provided, Trust Board is advised that it is able to make the required self-certification in relation to training of governors.
Recommendation:	**Trust Board is asked to confirm that it is able to make the required self-certification in relation to the Corporate Governance Statement and training for governors.**
Private session:	Not applicable

Corporate Governance Statement 2014/15

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Evidence of achievement/compliance

To make sure that the care the Trust provides is safe, effective, caring and responsive for patients, the Trust and its Board is founded on and, supported by, a strong governance structure. Corporate governance is the means by which Trust Board leads and directs the organisation to ensure decision-making is effective and the right outcomes are delivered. For the Trust, this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users. Robust governance structures to encourage proper engagement with stakeholders and strong local accountability support the Trust to maintain the trust and confidence of the people and communities it serves.

Good corporate governance includes oversight of quality governance. Robust corporate and quality governance arrangements complement and reinforce one another. Staff working in clinical teams providing Trust services are at the front line of ensuring quality of care to patients; however, it is Trust Board that takes final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care. Effective governance, therefore, requires that Trust Board is concerned as much with quality of care and quality governance as it is with the financial health of the Trust.

During its application process for foundation trust status and since authorisation, the Trust has implemented, developed and improved its corporate governance arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties. As part of this continuous improvement process, the Trust is currently reviewing the Monitor document "Well-led Framework for Governance Reviews" and a project plan will be developed and implemented, led by the Director of Corporate Development in her role as Company Secretary on behalf of the Chair and Chief Executive of the Trust.

There are a number of areas to provide assurance to Trust Board that the Trust applies principles, systems and standards of good corporate governance.

The Trust's Constitution is the key document underpinning its governance arrangements and the Trust operates effectively within its constitution at all times. To ensure its Constitution meets statutory requirements, the Trust seeks external advice and expert guidance on any changes to its Constitution and ensures amendments are approved in line with the process set out in the Constitution.

Trust Board receives assurance of the Trust's compliance with the NHS Constitution on an annual basis. Trust Board confirmed its assurance that the Trust complies with all relevant rights and pledges set out in the Constitution 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". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this

inappropriate. A further self-assessment was presented to Trust Board in June 2013 following changes to the Constitution as a result of the Francis Report and this will be repeated in July 2014.

Monitor's Code of Governance sets out a framework for the systems and processes to support the Trust's governance arrangements. A self-assessment against the revised Code, presented to Trust Board in March 2014, demonstrated that the Trust complies with the Code. A small number of actions were identified to develop and improve existing arrangements, for example, development of a governance handbook for Trust Board and revision of the Involving People Strategy. Internal audit will undertake a formal audit of the Trust's compliance in July 2014, which will be reported to Trust Board. The Trust's compliance with the Code will also be presented to the Members' Council in July 2014.

The Trust has a register of interests in place for both Trust Board and the Members' Council. This is reviewed on an annual basis and both Directors and governors are proactively asked to update their declaration. Directors and governors are also asked to declare any additions or changes to their interests at each Trust Board or Members' Council meeting. The Register of Interests for both Trust Board and the Members' Council is available on the Trust's website. There are no material conflicts of interest on Trust Board.

All elections to the Members' Council are held in accordance with the election rules contained in the Trust's Constitution and are managed for the Trust by Electoral Reform Services to ensure independence and transparency.

The Trust's governance arrangements are underpinned by the Quality Governance Framework (see section 5). The Trust also has robust arrangements in place in relation to performance and risk management (see section 4).

Under the Health and Social Care Act 2012, the Trust, as a foundation trust, was awarded a Licence automatically by Monitor from 1 April 2013. The Trust undertook a self-assessment against the conditions of the licence and provided assurance to Trust Board in March 2013 that it was able to meet and to continue to meet the terms of its licence. This was followed by an internal audit of its compliance in March 2014, which provided substantial assurance that the Trust meets the conditions of its licence. The Trust continues to ensure it can meet its licence through a process of self-assessment and will review further guidance from Monitor on areas that have yet to be finalised, for example, the risk pooling arrangement. Trust Board confirmed it was satisfied that the Trust is fully compliant with its licence and will remain so, and that there are no likely risks currently to compliance. Should any risks emerge, Trust Board is satisfied that action plans to address non-compliance would be in place to mitigate these risks and ensure ongoing compliance.

A number of other areas provide assurance to Trust Board that the Trust has good corporate governance arrangements in place.

Monitor's governance risk rating represents its view of governance at the Trust and the Trust has been assigned a green governance risk rating at quarter 2013/14 by Monitor. This follows achievement of a green risk rating throughout 2013/14. Monitor will make no further changes to its regulatory approach as a result of its review of the Trust's two-year operational plan, which was approved by Trust Board in March 2014.

The Head of Internal Audit Opinion for 2013/14 provided significant assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal audit reviews of the Trust's corporate governance processes have also provided substantial assurance opinions.

In terms of ongoing provision of services, the Trust has agreed and signed contracts with its commissioners for the financial year 2014/15.

As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in Monitor's NHS Foundation Trust Annual Reporting Manual. The Annual Governance Statement for 2013/14 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.

The Trust's assurance framework has been assessed by the Trust's internal auditors as satisfactory as part of an internal audit on risk management processes. A number of minor recommendations were made in relation to improving the assurance framework as a tool for Trust Board and these will be implemented to inform reporting to Trust Board. The assurance framework meets guidance issued by the Department of Health and links directly to organisational and individual director objectives. It provides assurance that key risks to delivery of the Trust's strategy are being addressed. The Audit Committee reviews the process to develop the Assurance Framework on an annual basis. The Trust also undertakes a self-assessment against best practice of the Assurance Framework, which is presented to Trust Board annually.

2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time.

Evidence of achievement/compliance

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from Monitor, an assessment of Trust's immediate position and any action or development required to ensure compliance.

3. The Board is satisfied that the Trust implements:

a) effective board and committee structures;

b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees; and

c) clear reporting lines and accountabilities throughout its organisation.

Evidence of achievement/compliance

Trust Board and Committee structures and responsibilities

Trust Board is clear that its role is to:

- formulate strategy;
- ensure accountability by holding the organisation to account for the delivery of the strategy and to seek assurance that systems of control are robust and reliable; and
- shape a positive culture for Trust Board and the Trust.

The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and for the public. Trust Board is clear of its accountability and responsibility.

The Board and Committee structures in place are effective and meet the Trust's Constitution. The Trust's Constitution allows for seven Non-Executive Directors, including the Chair, and six Executive Directors, including the Chief Executive. There are currently six Non-Executive Directors and five Executive Directors. Any appointment of an additional Non-Executive Director or of a voting Executive Director would be matched by a corresponding increase in Non-Executive or Executive Directors. Business Delivery Unit (BDU) Directors attend Trust Board quarterly (business and risk meetings) to provide operational assurance on the Trust's performance, use of resources and service delivery in a

non-voting capacity. The Company Secretary role is incorporated into the Director of Corporate Development's portfolio. The role is non-voting; however, she attends all Trust Board and Committee meetings (with the exception of the Remuneration and Terms of Service Committee) and this supports effective linkages between Committees.

Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust has four risk-based Committees:

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

Committees are chaired by a Non-Executive Director and have Non-Executive and Executive Director membership. Agendas, which are risk-based, are compiled and agreed by the Chair of the Committee in conjunction with the Lead Director. Each Committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Director of Corporate Development in her role as Company Secretary, that papers are commissioned to meet the requirements of the Committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to improve its services and Quality Academy support for services.

From time-to-time, Trust Board also establishes time-limited Forums, led by a Non-Executive Director, to scrutinise a particular area in more detail. There are two such Forums in place currently in relation to estates, and information management and technology.

The membership of Committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors.

The Committee structure was reviewed and considered fit for purpose for the Trust as a foundation trust on authorisation and has since been reviewed for appropriateness by both the former and current Chairs.

Each Committee is required to prepare an annual report, which is presented to the Audit Committee. This sets out and provides assurance to Trust Board that each Committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference.

Led by the Nominations Committee, there is a planned approach for the recruitment or re-appointment of Non-Executive Directors, which is managed on behalf of the Committee by the Director of Corporate Development, to ensure vacancies are filled in a timely way ensuring the skills and experience of Non-Executive Directors meet the needs of the Trust and to ensure there is effective succession planning. For example, when considering the skills and experience of the Non-Executive Director to replace Bernard Fee in May 2014, the Committee took the decision to recruit a qualified accountant who could replace Peter Aspinall as Chair of the Audit Committee at the end of his term of office in 2015.

The Chief Executive regularly reviews his Executive Management Team (EMT) for fitness for purpose and to ensure the skills and experience of the Team meet the needs of the Trust.

For example, when the Trust's District Service Director for Calderdale and Kirklees left the Trust in July 2013, it provided an opportunity to review and consolidate the senior level structure for all four locality-based BDUs to support the transformation programme. The Chief Executive, in consultation with the Chair of the Trust, 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, 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.

The Chief Executive has also reviewed the role, function and timing of all Executive Management Team meetings to provide the focus for 2014/15 on the year of delivery and year of values. The sequencing of meetings has been realigned to focus on transformation and organisational development, strategy and risk, providing an external focus, and delivery, providing an internal focus on performance and delivery of corporate objectives. These meetings are aligned to Trust Board processes to ensure Directors receive assurance regarding the Trust's operations. The Chief Executive has also introduced the weekly Operational Requirement Group to ensure and facilitate the effective operational delivery of the two-year operational plan. This Group is aligned and linked to existing EMT processes.

Trust Board is ably supported by an involved and proactive 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.

Reporting lines and accountabilities

The Trust works within a framework that devolves responsibility and accountability throughout the organisation by having robust service delivery arrangements. Last year saw 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.

The Chief Executive has 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 and 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.

4. The Board is satisfied that the Trust effectively implements systems and/or processes:

a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

There are a number of areas to provide assurance to Trust Board.

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2013/14. There were no issues identified that would need to be reported in the audit opinion.

The Trust's internal audit plan is risk-based to enable the Trust to identify areas of weakness and to learn from best practice. During 2013/14, there were 19 internal audits completed of which three reports provided 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.

In 2013, KPMG, 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. The Chief Executive has also commissioned a review of the Quality Academy to ensure it is fit for purpose to support BDUs in the current challenging climate. This will report in June 2014.

The Trust is required to report quarterly to Monitor on its performance. At quarter 4, its governance risk rating remained 'green' with a continuity of services remaining at level 4 as forecast. Monitor has confirmed that it does not intend to change the Trust's monitoring reporting arrangements.

The reference cost index (RCI) is a measure of relative efficiency and provides comparison at aggregate level for each trust to the national average. A RCI of 100 would demonstrate that unit costs were in line with national average. Organisations with lower RCIs are estimated to be more efficient than organisations with higher RCIs. The Trust's reference cost index for 2012/13 was 97. This equates to the Trust providing services at £6.2 million less than average costs.

The Trust has developed and implemented service line reporting (SLR), which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Whilst the Audit Committee is assured that the processes and systems are in place for SLR, it has asked for further assurance on the implementation and use by BDUs and that the Trust is using the information to benchmark internally, learning from best practice.

b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

Trust Board receives performance reports on a monthly and, for human resources and patient experience, quarterly basis, which enables it to satisfy itself that the Trust is meeting its financial and performance targets. Other reports to Trust Board provide 'soft' information that the Trust is fulfilling its purpose in an effective and efficient manner.

c) to ensure compliance with health care standards binding on the Licensee, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

The Trust was registered by the Care Quality Commission with no conditions in March 2010 and, again, in May 2011 following the transfer of services from Barnsley, Calderdale and Wakefield under Transforming Community Services. This involved a rigorous self-assessment process based on evidence gathering, which was scrutinised by Non-Executive Directors. There is an ongoing quarterly self-assessment process, which is reported to the Clinical Governance and Clinical Safety Committee. An internal audit in February 2013 provided an assessment of moderate assurance with four medium and one low priority recommendations. Self-certifying compliance with CQC standards is a key responsibility of Trust Board and it requires assurance that the information on which it bases its declarations is robust. The systems that allow these assurances to be made are a key part of the Trust's corporate governance framework.

The Trust has two compliance actions from the inspection visit to Fieldhead (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises). The submitted action plan addressing environmental improvements was fully completed by 31 May 2014. There is also an outstanding report following the inspection visit to Fox View made in January 2014 where the outcomes inspected were 4 (care/welfare), 6 (co-operating with other providers), 7 (safeguarding), 13 (staffing), and 21 (records). The CQC continues to monitor the trust in regard to admission of patients to wards when no beds are available, environmental standards relating to seclusion rooms and the level of cancellation of section 17 leave.

Mental Health Act visits occur regularly and, following each visit, an action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act Committee. From September 2014, the detailed action plans in relation to clinical and estate recommendations will be scrutinised by the Clinical Governance and Clinical Safety Committee from a clinical safety and quality perspective. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licensee's ability to continue as a going concern);

Based on evidence provided by finance and performance reports and the two-year operational plan for 2014/15 and 2015/16, supported by Audit opinion, the Trust will remain a going concern at all times. As part of its accounts audit for 2013/14, the Trust's external auditor, Deloitte, was able to agree with management's view that the Trust could continue as a going concern for the next twelve months.

Trust Board considered and approved the Trust's two-year operational plan 2014/15 to 2015/16 in March 2014. Trust Board provided robust challenge in a number of areas focussing on:

- the cost improvement programme, the timescales for achievement and the feasibility of achieving such a challenging programme;
- the Quality Impact Assessments undertaken to assess risk to services and the assurance this process provides to Trust Board;
- the Trust's transformation programme and how and when it would produce the service changes and efficiencies needed for future years;
- workforce efficiencies and changes required to support transformation;
- the Trust's proposed capital programme to support service transformation;
- how Trust Board would receive assurance that the plan was deliverable.

As a result of the discussion, Trust Board asked for an independent review and scrutiny of the plan and the Trust's plans for implementation with a report to its April meeting. Following discussion with the Chair of the Audit Committee, the Chief Executive commissioned Deloitte to undertake the review. The review was presented to Trust Board in April and a number of recommendations made, which were accepted by Trust Board and for which management action is in place. The Chief Executive has established an Operational Requirement Group, meeting weekly, chaired by him and involving Quality Academy and BDU Directors. The purpose of the Group is to ensure that the management action against the recommendations are owned and robustly managed by the Executive Management Team, action is implemented as agreed and delivered to time, and, where this is not possible, a strong rationale and mitigating action are in place to provide assurance to Trust Board that risk is being managed. This will be supported by strengthened and more robust performance reporting to Trust Board from quarter 1 of this financial year. Deloitte will undertake a further review in September 2014, which will support the assessment of the end-of-year outturn position to Trust Board in October 2014. Trust Board has also asked that this position report includes reporting of the position for 2015/16.

Following its review of the Trust's two-year operational plan, Monitor's current view of governance at the Trust is reflected in a 'green' rating at quarter 4 of 2013/14 and has accepted the Trust's forecast continuity of service risk ratings of 4 for 2014/15. It did, however, highlight two risks from the review.

- A key risk for the Trust is the potential loss of contract income and margin as a result of commissioners competitively tendering services currently provided by the Trust during 2015/16 or later years; and
- Achievement of planned levels of cost savings over the operational plan period will be challenging. Cost savings are 5.6% and 4.9% of operating expenditure during 2014/15 and 2015/16 respectively, which is higher than historic levels and exceeds the 4% national efficiency requirement.

These two areas will form an integral part of performance reporting to Trust Board through the robust monitoring and reporting of the Trust's performance against its two-year plan.

The Trust is also required to submit a five-year strategic plan to Monitor, which will be presented to Trust Board in June 2014. Monitor requires Trust Board to make a declaration of sustainability as part of the plan. This will be made following consideration of the Trust's current and future position, the local health economy and the consideration of the wider health context, as well as local and national challenges.

e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making;

f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence;

g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery; and

See d) above.

h) to ensure compliance with all applicable legal requirements.

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

5. The board is satisfied that the systems and/or processes should include, but not be restricted to, systems and/or processes to ensure:

a) that there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;

b) that Trust Board's planning and decision-making processes take timely and appropriate accounts of quality of care considerations;

c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care;

d) that Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;

e) that the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f) that there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.

Evidence of achievement/compliance

Trust Board approved the adoption of a seven-step quality improvement framework (QIF) during 2013. This framework has been utilised to develop a systematic approach to quality improvement throughout the organisation and a Quality Improvement Strategy was developed following a review of the Trust's position against its seven quality priorities using the QIF. This was approved by Trust Board in September 2013.

Trust Board has used Monitor's Quality Governance Framework as a basis for providing assurance that the Trust has systems and processes in place to deliver quality services. On its introduction in 2012, the Trust undertook regular reviews against the Framework identifying a range of evidence to demonstrate compliance with the criteria. This evidence includes:

- policies developed, reviewed and in place;
- governance systems;
- the assurance framework and risk register presented to Trust Board quarterly;
- audits undertaken both internally and externally;
- the programme of unannounced visits; and
- reports submitted to Trust Board and its Committees, as well as the Members' Council.

A number of internal reviews were undertaken and, from these, a number of areas were identified for development; however, an assessment by the Director of Nursing considered that none were of sufficient risk to preclude Trust Board from continuing to make the quality statement on a quarterly basis.

In December 2012, internal audit completed an audit of the Trust's compliance with the Framework. Monitor's authorisation criterion is that a Trust must score 3.5 or less and have no overall domain with all questions rated entirely amber/red. On the basis of this guidance, the Trust achieved a score of 1, which means that the governance arrangements for the Trust would meet Monitor's requirements. KPMG also gave an assessment of substantial assurance in its final report. The three recommendations made (one low and two medium) have been addressed.

The Trust produced its Quality Report in 2013/14. Quality Reports provide a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report for 2013/14 was externally audited and Deloitte was able to provide the required limited assurance opinion on the content and consistency of the 2013/14 Quality Report and that:

- the content was in line with the Annual Reporting Manual (2013/14) issued by Monitor and consistent with documents reviewed;
- the format reflected the recommendation to provide greater explanation of data tables;
- areas of good practice related to a clear statement of future priorities and how these will be achieved, use of tables and graphs, and the concise presentation of information.

In terms of the performance indicator testing of two mandatory targets (seven-day follow up and crisis resolution) and one local target (monitoring and measuring of medication errors), the overall conclusion was satisfactory subject to implementation of a number of recommendations, which had been accepted by management. During the audit, an issue in relation to seven-day follow up came to light. The Trust's position was supported by both Deloitte and Monitor. The Trust will, however, be required to achieve its performance target in quarters 1 and 2 of 2014/15 for the seven-day follow up target.

As part of its response to the challenges facing health and social care and the need for continuous service improvement, the Trust has begun a programme of transformational change across its services and updating and developing its existing plans to ensure it continues to offer the best services possible.

During the annual planning process for 2013/14, a robust process was introduced by the Director of Nursing to assess risk to and impact on quality and safety of cost improvements proposed by BDUs. This process continued for 2014/15. The Quality Impact Assessment, led by the Director of Nursing and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the EMT and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements would not have an adverse effect on Trust services. .

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its Committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The changes at Director level have enabled a stronger management structure to be developed for each BDU with the appointment of deputy directors providing operational leadership and management. This allows BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. This 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.

The Trust's approach to clinical quality improvement is supported by the Quality Academy approach, which is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda. The Chief Executive has commissioned a review of the Quality Academy to ensure fitness for purpose in the challenging environment the Trust faces and this will report in June 2014.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board. Areas where Trust Board has set stretching targets and commissioned action plans to improve performance include sickness absence, data quality, estates and the Trust's approach to information management and technology. Board-level forums to provide more detailed assurance have been established in the last two areas, led by a non-executive director.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service users experience is set out in its Involving People Strategy. Regular meetings are also held in community and ward settings to receive service user and carer feedback. As part of the Quality Academy approach, the Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact and a service user insight framework has been introduced.

The Trust continues to be a national leader in the development of the Pathways and Packages approach to organising care and the implementation of this approach and this has formed the foundation of the Trust's approach to service line management and currency development. The Trust's approach is monitored through the Audit Committee in terms of finance and the Clinical Governance and Clinical Safety Committee in relation to the impact on clinical services and assurance provided to Trust Board through Key Performance Indicators and specific reports. The Audit Committee has asked for further assurance on the implementation of and use by BDUs in their day-to-day operations.

Trust Board continually reviews its approach to quality improvement, linked to updates on the development of the Quality Academy approach and performance against contracts with commissioners, QIPP and CQUIN targets.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection

Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing, Clinical Governance and Safety, include checks for cleanliness. PLACE assessments provide third party validation of the assurance provided to Trust Board. The Trust scores for each of the facilities were above the national average except for Privacy and Dignity in Enfield Down, The Poplars and Castle Lodge. The areas below the national average were community units and as a result of their size had problems related to identifying male and female designated lounges, family visiting areas and multi-faith rooms. The Trust is working with the service managers to see how we can improve the environment within our community units, to improve the privacy and dignity, although it is recognised that the physical limitations within smaller buildings presents particular difficulties.

The Trust adopted a balanced and measured approach to the publication of the Francis Report. Trust Board support for this approach was given in February 2013 and a series of Trust-wide workshops involving staff from all areas of the Trust have been arranged for the end of April 2013. Wherever possible, action has been incorporated into existing processes and procedures. The Trust will publish information in relation to the Friends and Family test for staff from June 2014.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services. During 2013, the Trust held two series of engagement events on its plans for transformation resulting in strong themes for the vision of Trust services. These themes have influenced development of the transformation workstreams and are a integral part of future service provision.

The Trust has also undertaken extensive engagement on the revision of its values to ensure these reflect service user, carer and staff views.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

6. Trust Board is satisfied that there are systems to ensure that the Trust has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Evidence of achievement/compliance

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board when appointing Non-Executive Directors to the Board. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary foundation trust board, a review of Trust Board skills and

experience is to be undertaken as part of the Trust Board development plan. This also reflects a recommendation from the Trust's internal auditor that the Trust undertakes formal process of assessment of Trust Board members, not only in terms of skills and experience, to identify gaps and enable effective succession planning but also to evaluate Trust Board's effectiveness.

Rigorous appointment processes are adopted for all Executive Directors. The most recent appointment was for the Director of Nursing and a robust and competitive national exercise was undertaken demonstrating the Trust's commitment to attracting the best candidates and to ensure that this key post continues to focus on quality improvement at the heart of Trust Board.

The job descriptions for the Chair, Non-Executive Directors, the Chief Executive and the Director of Finance have been matched against the model job descriptions provided by Monitor.

All new Non-Executive Directors have had a detailed induction programme tailored to individual requirements and Board responsibilities. A programme of ongoing Board development is in place, using external expertise where required. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors and Council Members.

The Chief Executive is subject to formal review by the Chair twice-yearly. Executive Directors are subject to quarterly appraisals by the Chief Executive and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee. An annual report will be presented to Trust Board in June 2014. The Clinical Governance and Clinical Safety Committee also received a report on the governance framework for medical practice, which provided assurance of the arrangements in place for medical staff.

Trust Board is satisfied that the management team has the necessary skills and competencies to deliver the business plan. All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the business plan. The Chair and Chief Executive will continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing, Clinical Governance and Safety and the Medical Director.

The Trust also has a programme in place for all managers within the Trust at Bands 7 and above, Middleground, which intends to align efforts and resources to shared organisational goals, ensure all effort and initiatives link together to create added value, ensure behaviours and actions are aligned to the organisational vision, values and goals, and ensure behaviours help produce performance, assurance and improvement at individual, team and organisational level. During 2012, the Trust developed an initiative to identify, nurture and develop talent within the organisation.

The Trust was successfully re-assessed as an Investor in People in 2012, which provides third party validation that individual objectives and development plans support the delivery of the Trust's overall strategy. It will seek accreditation against the IiP gold standard during 2014.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 9

Title:	**Calderdale Community Hub – Full Business Case**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	This paper seeks Trust Board approval for the construction of a new build Calderdale Community Hub in Halifax town centre. The cost of the development means it requires the Board to approve the Business Case.
Mission/values:	The Trust's service strategy is to provide services as close to people's homes and communities as possible. The construction of a Calderdale Community Hub is in line with the BDUs service model and the Estates Strategy.
Any background papers/ previously considered by:	This proposal is linked to the Trust Estate Strategy agreed by the Board in 2012. The Outline Business Case has been approved by EMT and also the Estates Forum who agreed to progress to a Full Business Case for the Board to consider. The purchase of the land to enable this construction was the subject of a Board approval in financial year 2013/14.
Executive summary:	The proposal is to build a new building on the site of the Former Laura Mitchell Health Centre close to the centre of Halifax. The proposed building will be constructed of a size to facilitate agile working for staff and will include flexible meeting rooms, high quality service user engagement space, fully compliant clinical facilities all within a welcoming and non-stigmatising surrounding. The building will house staff and service users currently in the following locations • Dean Clough • Broad Street • Britannia Works • School House • Elmfield House The proposal will enable the cessation of leases for the first four buildings and the disposal of Elmfield House. This will reduce revenue costs for estate significantly in the BDU the full extent of the savings is addressed in the paper with supporting financial documentation in the appendices. The new build means a higher capital cost that originally anticipated, however, it is affordable with the limits of the current Capital Programme without compromising other strategic schemes.
Recommendation:	**Trust Board is asked to approve the construction of a hub in Halifax of approximately 2038 square metres.**
Private session:	Not applicable

TRUST BOARD: 24 JUNE 2014

FULL BUSINESS CASE

PROVISION OF CALDERDALE HUB

1. PURPOSE OF THE REPORT

This report outlines the proposal to form the Calderdale Hub on a site recently acquired by the Trust for this purpose close to the town centre of Halifax. The new hub will replace four leased buildings and one Trust owned property which will lead to reduced estate revenue costs and a one off capital receipt. The development will be in line with the hub concept agreed in the most recent Estate Strategy; the premise will be non-stigmatising and will reflect the SWYPFT brand. The development is designed on the Trust agile working principles which are the main driver behind reducing the estate costs through reduced building area. The building will also improve service delivery through the provision of a single high quality delivery point for services.

2. BACKGROUND INFORMATION

Estate provision within Calderdale is centred around the Dean Clough Mills which the Trust occupies under a sub-lease to the Department of Health (DoH) at an advantageous rent. Essentially the Trust does not contribute to any common areas and has free access to meeting facilities this is estimated as a benefit of approximately £110,000 per annum, in addition the Trust is not charged VAT on the lease or utility and soft FM charges as this is met in full by the Department of Health and not passed on. This lease ceases in September 2014 and the DoH have indicated they will surrender the lease meaning the Trust would need to renegotiate or find new accommodation. Should the Trust wish to remain in occupation the full cost would not represent good value.

In addition a number of other leases will cease around the same time it makes economic sense to wrap up this accommodation into a single premise as well as aid access to services through a single point, this forms the “hub” concept within the Estates Strategy. In addition the agile working methodology agreed by the Trust was seen as applicable to the new hub and a search for suitable sites was launched in the rental market, during this search the former Laura Mitchell Health Centre was identified as being marketed for disposal by CHFT, although this would involve an acquisition and a build rather than a rental the benefits of the site i.e. its central location were considered ideally suited to the hub concept, the site also housed an existing large building which could be considered as a potential basis for refurbishment. The site was purchased at an advantageous rate purely at its land value encumbered by a building that would require demolition.

Subsequent to purchase the building was considered for its potential to accommodate the Trusts needs however, detailed structural surveys not possible during purchase indicated the onset of concrete carbonisation (a slow acting degrading of the concrete which affects its strength and effective life) which rendered the building frame unsuitable for an extended economic life. The design process has since concentrated on a new build based purely on the Trusts needs in a purposed designed hub.

Whilst the new build approach will add to the Trust's initial costs the asset will be available for and depreciated across a longer period than a refurbished or rented facility so does represent good value.

Taking into account the cost of the capital and the funds needed to run the development the revenue costs associated with the new hub represent a substantial annual reduction against the lease and running costs of the existing provision. Assuming the Trust authorises a build of 2,038m² then the Trust will be able to release the Dean Clough, School House, Broad Street and Britannia Works leases. The savings appendix at 1 reflects this scenario

The release of Elmfield House will give a one off capital receipt of approximately £250,000 and reduce outstanding backlog maintenance by approximately £12,000 in addition to the removal of the recurrent revenue costs this is also shown at appendix 1.

Whilst the estate related benefits of the development are considerable more importantly the service benefits to staff, service users and commissioners are the main drivers behind this development these are briefly outlined below.

The main benefit of the development is to the Trust and its service users for the following reasons:

- No direct decant costs will be needed for the proposal as the premise of the development is agile working affected staff will be "early adopters" of the concept so that they will bring this work style to the new site. Staff based at Dean Clough will be based at other Trust properties from the lease ending through to the completion of the new build so will commence agile working in anticipation of the work styles to be adopted at the Hub.

- Services will be available in one location close to transport infrastructure

- Clinical services will be co-located enabling cross working between teams and opportunities to enhance communication

- The building will provide a welcoming non stigmatising environment.

- Staff will be able to adopt agile work styles which can benefit their work life balance and to meet service users' needs by adopting new ways of working.

- Service users will benefit from improved facilities than those enjoyed in some of the leased properties.

- The quality of the estate will enhance the value of modern mental health care in the wider community and contribute to reducing stigma.

- The Trust will have security of tenure due to owning the freehold of the premise.

- The Trust will have an asset with a substantial value.

- The Trust will enhance its reputation as a leading practitioner in the field as it provides the highest standard of facilities to the widest possible group.

- The commissioning environment the Trust operates in has changed substantially and is continuing to develop; the Trust needs to be able to react to existing and future challenges. This scheme will indicate to Commissioners that the Trust is willing to invest in market leading facilities from which to fulfil its contractual obligations.

- The multidisciplinary aspect of the hub concept means that many users will have a single site for differing needs improving accessibility.

- The new building will be constructed to the latest standards which will enhance the healing environment and reduce the Trust's revenue liabilities.

- The increased efficiency of having service provision in a single place means that the development can act as a catalyst for cooperative working and could lead to income generation.

It should be noted that this proposal is based upon the Trust's desire to achieve class leading facilities as part of its offer to commissioners as a 'value added' delivery strategy. This will enhance the reputation of the Trust as a provider of choice.

3. STRATEGIC CONTEXT

The 5 Year Capital Plan references the redevelopment of hubs as part of the overall plan. Within the plan the hub concept is referenced across the Trust area the Calderdale hub will be the first of these developments to be purpose designed and will act as the "benchmark" for the future.

The Trust strategy for a reduced estate footprint consisting of higher quality buildings is clear in the 2012 Estate Strategy, whilst this building will be owned rather than rented it is designed with the same principles in mind and will bring the Trust brand to the Calderdale BDU estate provision.

4. FINANCIAL CASE AND SERVICE BENEFITS

4.1 Financial Case

The recurrent revenue cost of the estate that this building will replace is currently at £771,000. If the benefits the trust enjoys through the subsidised rent are factored in then the true cost of the current space is £962,000 per annum. With projected revenue costs of £294,000 per annum and including the cost of the capital for the new build at £303,000 per annum there will be a recurrent saving to the Trust of £365,000 per annum which will contribute to the Trusts savings targets. In working these savings through to savings across a five year period the outturn figures are in the table below

	Annual £k	**Year 1 – 3 £k**	**Year 1 – 5 £k**
Current Revenue Costs	962	2,100	4,024
New Revenue Costs	(294)	(881)	(1,469)
Revenue Reduction	668	1,219	2,555
Cost of Capital	(303)	(795)	(1,412)
Total Cost Reduction	365	424	1,143

This table demonstrates the comparison of current revenue costs to proposed costs around Laura Mitchell. This consists of both revenue costs and costs associated with the Trust investing in capital.

Using a Net Present Value calculation this comparison shows the cost reductions forecast as at year 1 and by year 3. The savings in year 1 – 3 are representative of the reduced revenue savings as some properties will still be occupied whilst the building is being completed.

This assessment excludes the initial capital investment which is included in the Trust capital programme. It also excludes the impact of any impairment.

The workings in appendix 1 show how these figures are made up from the individual buildings and give a comparison to the Folly Hall hub which is also a leased building. For completeness Life cycle costs have been included using industry standard data and an industry standard life for this building of forty years (The Trust has chosen to write off the capital value of the development over 40 years as prudential management, it is recognised that some of the elements of the building have a longer life of up to ninety years so the forty years is an average figure for all the elements which has been used in previous business cases). The Life Cycle costs are summarised in Appendix 2
Construction of a new building will allow the trust to reclaim some elements of VAT as the construction is to be used for service benefits

the full extent of the VAT reclaim will be calculated after completion of the scheme so these benefits have not been included in the Business case as it is not known when they will be achieved, this approach is in keeping with all previous business cases.

4.2 Service Benefits

Whilst this scheme delivers significant financial benefits to the trust it is important that it also improves services to our users. To this end the existing facilities have been considered against the new provision and the benefits can be summarised as follows

- Service is currently delivered from a number of different sites with accommodation at differing qualities this can be perceived as certain services being delivered in lesser or better surroundings this has been shown to impact on the perception of the services provided, this development will mean that all services will be delivered in the same surroundings removing these perceptions.

- All service user areas will be designed to the latest healthcare guidelines ensuring that the Trust delivers in high quality fit for purpose surroundings.

- Clinical space can be more efficiently designed to meet modern contemporary mental health care

- A safe therapeutic and staff working environment can be provided which will aid positive staff working and service user recovery.

- The hub represents significant investment by the Trust in a site that has a history of delivering healthcare in Halifax. This legacy of community health delivery will also add to the buildings non stigmatising design principles.

- Whilst the Trust seeks to deliver a seamless journey through its services this can be compromised by users having to negotiate a geographical as well as a service pathway. The ability to deliver service in a single point of access is a major benefit to the Trust in achieving this goal.

- The BDU staff will similarly benefit from co location into a single centre. Currently some key staff groups are separated by geography which can introduce a level of “silo” working; whilst this is currently effectively managed it is not a totally seamless service co location will improve this inter-operability between disciplines, most notably for psychologists who are wholly separate from most other services.

- Outpatient visits are managed through facilities in the Dales which also houses inpatient services. The BDU has evidence that service users actively avoid appointments at the Dales as these Outpatient visits to the Dales are seen as part of the journey back into inpatient care. This is reducing successful outcomes for some service users.

- Waiting facilities at the Dales are wholly inadequate with corridors being used as waiting areas. The hub will have dedicated and discreet waiting areas for the various services which will ensure a pleasant and safe environment. The development has been sized with a reception area that can, subject to a further business case, accommodate a café which as well as providing income and employment opportunities for service users will be a standard commercial environment in which to meet, engage and improve whilst receiving care in the rest of the building.

- The BDU support functions to the clinicians will improve in quality as they are brought together, whilst this will not bring a "cash releasing" benefit at this stage it will give an "efficiency saving" which will be considered as a possible cash benefit in the short term savings plans.

5. COST IMPROVEMENT PROGRAMMES

This scheme will contribute significantly to the Trust's revenue savings as shown on the table at 4.1 over the first five years of its life the scheme will contribute a saving of £1,143,000 after all capital costs have been attributed to the building whilst providing an improved flexible environment in which to deliver care.

6. DESCRIPTION OF THE PROPOSAL

The proposed scheme is for a new building to be constructed on the existing site situated on three floors and covering approximately 2,038 m^2. The building will have dedicated clinical spaces with appropriate separation between child and adult service users, additionally the building will house dedicated bookable meeting space and will offer open plan office space designed on the principles of agile working. The reception area will be sufficiently sized to accommodate a small café subject to it being proven to be a viable proposition or will act solely as a 'business lounge' to further enhance the agile working principles on which the building is designed. The site is within a conservation area so the palette of materials for the external elevations will reflect that. The reception, meeting and clinical areas will reflect the Trust premises branding which has been developed as an extension of the existing corporate identity. The development will incorporate parking to the rear of the site which will be strictly managed to ensure it works effectively.

7. ANALYSIS OF THE PROPOSAL

7.1 Resource Implications

7.1.1 **Workforce**

The proposal is neutral in terms of staff numbers but will require a substantial number of staff to be equipped to work in an agile manner, this work predates building occupation and is driven by the need to reduce estate footprint to maintain the viability of the BDU and Trust as a whole.

7.1.2 **Estates**

The proposal will attract costs for energy usage, maintenance and rates these costs have been incorporated into the revenue costs and form part of the projected savings. Whilst it is anticipated that the building will have an increased maintenance need due to the additional facilities and the need to ensure the premise remains safe in use these will be offset by the removal of the service charges associated with the existing leases. Analysis of the life cycle costings sets the additional recurrent maintenance costs for the new building at £60,360 per annum these will require additional funding to the facilities revenue maintenance budget.

7.1.3 **IT Infrastructure**

The IT requirements for the scheme are captured within the capital scheme.

7.2 Financial Implications

7.2.1 **Capital**

The scheme has been estimated at £5.26 million to design and build (exclusive of Trust equipment costs at £225,000) before any VAT recovery is applied this cost has been projected into the current capital plan and is affordable within the limits already agreed by Board for the provision of Hubs throughout the Trust area, the increased costs will also be contained within the overall capital limit set by Trust Board. The cost has been produced by the P21+ partner and is therefore robust. This cost does represent an increase in the initial assessment as the option to refurbish the existing building or to construct a building at 1,800 square metres either cannot or have not been pursued.

Following development of the designs during the approvals phase of the project our P21+ partner remains confident that the proposal can be constructed within this financial envelope.

Subject to Board approval the scheme will be taken to a stage where the Guaranteed Maximum Price can be set.

7.2.2 **Revenue**

The revenue costs associated with the proposal are shown to reduce due to the efficiencies of a single site and the adoption of agile working over the projected life of the building the recurrent revenue savings are substantial and will contribute to the financial viability of the BDU. Projections of the costs and savings associated with the development are shown in Appendix 1.

7.3 Constraints on Delivering the Proposal

The case for bringing forward this scheme is predicated on delivery being through the existing P21+ contract and costs have been estimated on this basis. The new development will be subject to planning permission and discussions have been held at an outline level with Halifax Council, whilst the proposal will be subject to full cabinet approval the proposal has been met with a very positive response from planning officials. The proposals are subject to further consultation based on service delivery with all stakeholders.

7.4 Impact of the Proposal on Stakeholders

7.4.1 **Service users**

The scheme will improve the environment for service users. This has been shown to provide clinical benefits and is one of the main drivers for the improvement.

7.4.2 **Staff**

Staff will have improved working facilities and a modern building to work in which fully supports agile working principles. Appendix 3 summarises where staff will relocate from to the new hub.

7.4.3 **Commissioners**

Commissioners will be commissioning service to the same standard of accommodation for differing services and will be able to receive assurances on the quality of the environment and the location of the service close to the town centre and associated public transport infrastructure.

In summary the proposal is a key enabler in providing a flexible responsive service which can be regarded as a destination of choice for the commissioner. The proposal will achieve reduced operating

costs through efficiencies of working which will benefit the Trust whilst further enhancing the Trust's reputation for delivering high class services in high class facilities.

8. OPTIONS FOR DELIVERING THE PROPOSAL

The proposal will be delivered through the existing P21+ framework so consistency of standards and quality can be assured

9. RISKS AND MITIGATION

The known risks associated with the development are as follows:

- Planning permission is not granted – to mitigate this we have entered into early discussion with the planning authority and they are happy with the principles of the scheme, we have also consulted with our neighbours to ensure they are aware of the proposal from the Trust rather than the council. This approach has proved to be beneficial in the past.

- The P21+ partner cannot deliver the scheme – the P21+ provider has assured the Trust that resources can be put in place to deliver the scheme.

- The cost of the project rises – The use of P21+ is a mitigating factor in protecting the Trust as the scheme will reach GMP very quickly following approval. This will set the maximum price we pay for the agreed design. The Trust, again without prejudice has sought a budget costing for the scheme under consideration from our P21+ partner.

- The scheme does not deliver to the agreed plan – a project plan has been drawn up in conjunction with the P21+ partner which has been used to decide timescales for decant provision. The plan used has been signed off by all parties.

In summary the construction risks of this project whilst very real are resolved by the use of an experienced P21+ partner who has delivered a number of large schemes ahead of time and on budget.

On addition to the specific construction risks the BDU also have identified some risks to service users and staff which will be addressed by the scheme board

- The SMS & HIS contracts are up for renewal later this year. If they are not awarded to the Trust then this is a risk but it would be hoped that again, the space they would have taken in the hub could be utilised by other organisations (perhaps the organisations that are successful in the tender process).

- The movement of teams from Dean Clough to alternative Calderdale bases has added pressure to clinic areas that are already highlighted as 'not fit for purpose', etc. If the hub were not to go ahead it would be doubtful that services could be delivered from existing bases in the medium to long term.

- The move towards transformation of services (and closer working relationships between professional groups) cannot be achieved in existing accommodation.

- Managerial and Administrative pressures are increased by providing cover of a many number of bases (as existing).

- Reputational risk associated with the delivery of services in poor quality accommodation.

10 EQUALITY IMPACT ANALYSIS

The development of the Calderdale Hub has included services users and members of staff.

The design of the building has been responsive to the feedback from both groups and subsequent revisions were made in response to views.

The design has considered all of the protected characteristics and has aimed to maximise the potential of the new building to reduce the stigma sometimes associated with mental health issues.

A key element of the equality impact assessment was the conscious development of a dedicated CAMHS area to ensure that children are protected whilst using our services. The building is flexible therefore enabling the services to respond to client need as the services expand and develop.

11. RECOMMENDATIONS

Board is recommended to:

- Approve the business case for Calderdale Hub including approval to proceed to Construction phase for the building at 2038 square metres.

Laura Mitchell Hub net present value of new building 2038sq.m

Headlines

The capital costs of the Laura Mitchell Hub is £5.486m at todays prices, including non costruction costs.
It is assumed the Laura Mitchell Hub building will have a 40 year lifespan.

Costs of Building	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
Investment (£000's)	£5,486															
Revenue Costs (£000's)	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	£291	
Depreciation (000's)		£99	£132	£132	£132	£132	£132	£132	£132	£132	£132	£132	£132	£132	£132	
Capital Charges (000's)	£192	£189	£184	£179	£175	£170	£166	£161	£156	£152	£147	£143	£138	£133	£129	
Impairment		£1,646														
Cost (£000's)	£5,969	£2,224	£606	£602	£597	£592	£588	£583	£579	£574	£569	£565	£560	£556	£551	£15,714
Discount Factor 3.5%	1	0.965	0.931	0.899	0.867	0.837	0.808	0.779	0.752	0.726	0.700	0.676	0.652	0.629	0.607	
NPV Cost (£000's)	**£5,969**	**£2,146**	**£565**	**£541**	**£518**	**£496**	**£475**	**£454**	**£435**	**£417**	**£399**	**£382**	**£365**	**£350**	**£335**	**£13,844**

Savings																
Current Revenue Costs	£513	£625	£962	£962	£962	£962	£962	£962	£962	£962	£962	£962	£962	£962	£962	
Discount Factor 3.5%	1	0.965	0.931	0.899	0.867	0.837	0.808	0.779	0.752	0.726	0.700	0.676	0.652	0.629	0.607	
NPV Cost (£000's)	**£513**	**£603**	**£896**	**£864**	**£834**	**£805**	**£777**	**£750**	**£723**	**£698**	**£674**	**£650**	**£627**	**£605**	**£584**	**£10,604**

Assumptions

Full VAT charged at 20% VAT . VAT reclaim will be applied to this project which will realise a significant return

Revenue costs - These are based on equivalent m2 costs of Folly Hall, plus additional costs relating to the increase in costs of security. These costs include assumptions around lifecycle costs.

Depreciaton costs - these are based on a 40 year lifespan of the building based on an overall cost of £4.915m.

Capital charges - these are based on the scheme costs at the PDC rate of 3.5%

Negative cash impact - There would be a loss of interest on the cash spent

Impairment -It is estimated that impairment will be around 30%, however a professional valuation would prove more accurate.

Risks

The key risk is that an impairment of higher than 30% would occur on completion which would effect the the Trusts planned surplus position, this could be mitigated by impairing in next financial year however discussions with the District Valuer and the Auditors is required before this risk can be mitigated

CALDERDALE HUB OPTIONS COSTING

	Note	Rent	Rates	Utilities	Domestics	Waste	Maintenance Costs	Insurance	Security	Phones	Data link	CCTV / Alarm System	Depreciation & Capital Charges	Fabric Maintenance	Total Running Costs	m²
Current Estate																
Dean Clough		399,622	67,979	24,612	14,625	237	369	3,978					1,527		512,949	1018
Broad Street		102,440	42,000	15,000	12,000										171,440	501
Brittania Works		27,308	4,438	1,419	7,706	378	277				3,000				44,526	151
School House	#will most likely occupy for a full year	99,500	34,000	14,000	10,000						3,000				160,500	964
Elmfield House			15,190	18,009	13,567	527	3,766				4,000		17,456		72,515	810
Total		**628,870**	**163,607**	**73,040**	**57,898**	**1,142**	**4,412**	**3,978**	**-**	**-**	**10,000**	**-**	**18,983**		**961,930**	

Note rental assumes payment for communal and meeting space plus charge for VAT which are not charged by DOH this is estimated at £180,000 per annum

Total **3444**

Calderdale Hub - New Build																
2038 m²	Based on Folly Hall		98,857	54,531	68,000	-	50,360	-	-	14,000	5,000	-		-	290,748	**2,038**
	Laura Mitchell rates (old Building)		6,190													

Folly Hall		**170969**	**539,540**	**141,300**	**75,392**	**78,000**	**2,854**	**5,726**	-				**113,055**		**955,867**	2,913
Folly Hall maintenance contracts																
120	Automatic doors															
267	Lifts															
120	Panic alarm															
123	Intruder alarm															
842	Access control															
4253	Mechanical maintenance															

Current Estate																
Dean Clough		512,949	513												512,949	
Broad Street		171,440	171												171,440	
Brittania Works		44,526	45												44,526	
School House		160,500	161												160,500	
Elmfield House		72,515	73												72,515	
Total		961,930	962												961,930	
Laura Mitchell		293,755	294													
Revenue Reduction		668,175	668													

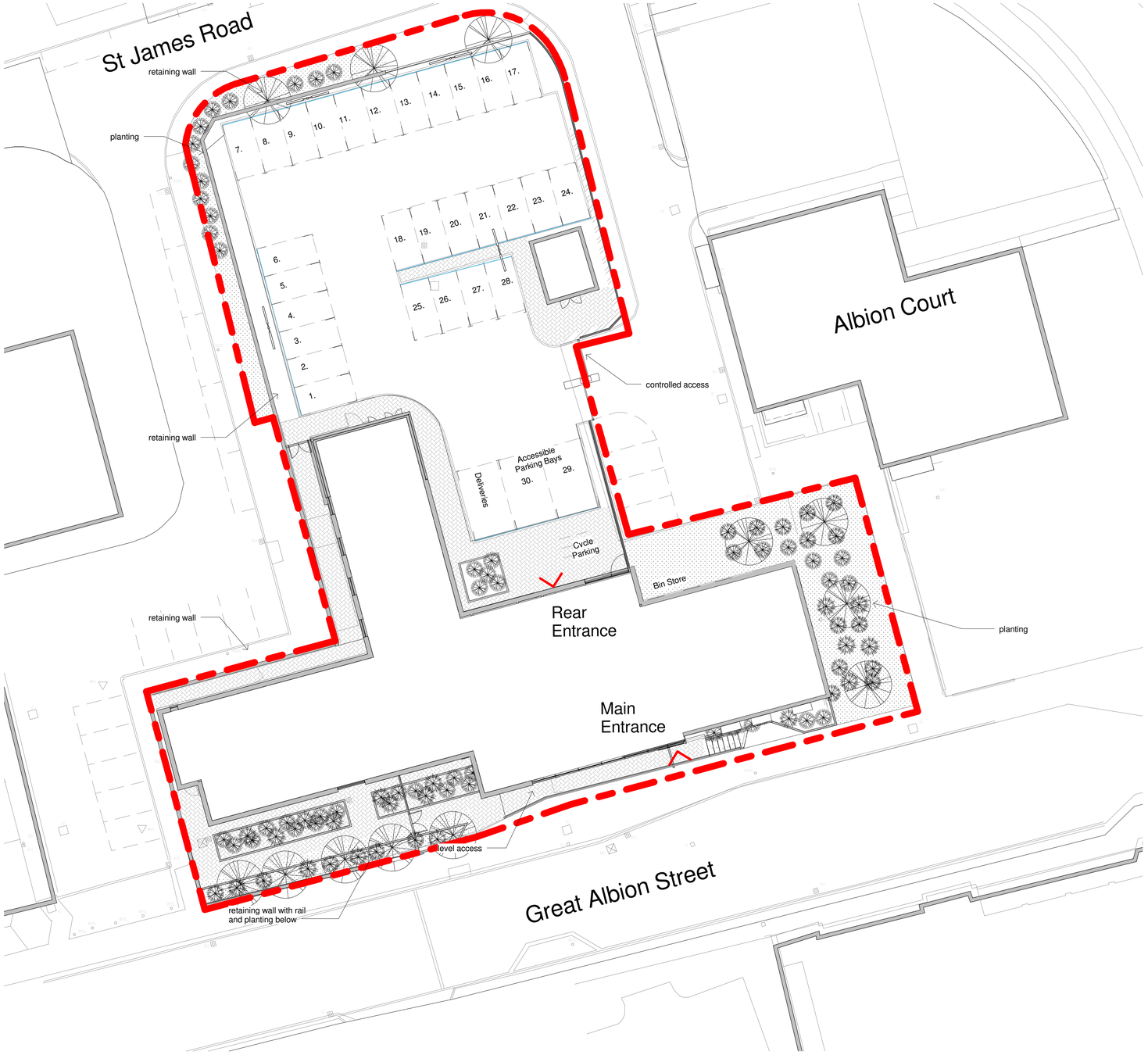
Project Title: Calderdale Hub			New Build Option	
Life Cycle Period of Analysis	40			
Base Date	4Q2013		GIFA	2038
Location (BCIS index)	-			
Construction Start Date			08/09/2014	
Construction Completion Date			21/08/2015	
Maintenance, Operation, Occupance Start Date			15/09/2015	
Discount Rate	0.00%			
			£	£
Construction Costs	1.0	**Construction Costs**	Category Costs	Total
	1.1	Construction Works Costs	3,273,761.98	
	1.2	Other Construction Related Costs	excl	
	1.3	Client Definable Costs	excl	
		Construction Costs		**3,273,761.98**
Periodic Major Replacement Costs	2	**Maintenance Costs (Major Replacement)**		
	2.1	Major Replacement Costs	907,264.78	
	2.2	Subsequent Refurbishment and Adaptation Costs	incl	
		Major Replacement Costs over 60 year period		**907,264.78**
Maintenance, Occupancy and Operation Costs		**Maintenance Costs (contd)**		
	2.3	Redecorations	incl	
	2.4	Minor replacement, repair and maintenance costs ie Fabric Maintenance	282,890.64	
	2.5	Unscheduled replacement, repair and maintenance costs		
	2.6	Grounds Maintenance costs		
	2.7	Client Definable Costs		
		Total Maintenance Costs over 60 year period		**282,890.64**
	3	**Operation Costs**		
	3.1	Cleaning	1,464,067.88	
	3.1.1	- Windows and External Services	incl	
	3.1.2	- Internal Cleaning	incl	
	3.1.3	- Specialist Cleaning	incl	
	3.1.4	- External Works Cleaning	incl	
	3.2	Utilities Costs	1,133,303.44	
	3.2.1	- Fuel	incl	
	3.2.2	- Water and Drainage	incl	
	3.3	Maint staff costs	793,834.67	
	3.3.1	- Property Management	incl	
	3.3.2	- Staff engaged in servicing the building	incl	
	3.3.3	- Waste management disposal	incl	
	3.4	Overheads Costs	excl	
	3.5	Taxes	excl	
	3.6	Client Definable Costs	excl	
		Total Operation Costs over 40 year period		**3,391,205.99**
	4	**Occupation Costs**		

Annual Mainte	4.1	Internal Moves (Churn)	excl	
	4.2	Reception and customer hosting	excl	
	4.3	Security	excl	
	4.4	Helpdesk	excl	
	4.5	Switchboard/telephones	excl	
	4.6	Post room - mail services/courier and external distribution services	excl	
	4.7	ICT and IT services	excl	
	4.8	Library Services	excl	
	4.9	Catering and Hospitality	excl	
	4.10	Laundry	excl	
	4.11	Vending	excl	
	4.12	Occupiers Furnityre and Fittings (FF&E)	excl	
	4.13	Internal Plants and Landscaping	excl	
	4.14	Stationery and Reprographics	excl	
	4.15	Porters	excl	
	4.16	Car Parking Charges	excl	
	4.17	Client Definable Costs	excl	
		Total Occupation Costs over 60 year period		**0.00**
End of Life Costs	**5**	**End of Life Costs**		
	5.1	Disposal Inspections	Excl	
	5.2	Demolition	Excl	
	5.3	Re-instatement to meet contractual requirements	Excl	
	5.4	Client Definable Costs		
		Total End of Life Costs		**0.00**
Whole Life Costs	6	**Non-Construction Costs**		
		Excluded from LCC Study		
	7	**Income**		
		Excluded from LCC Study		
	8	**Externalities**		
		Excluded from LCC Study		
		Total Whole Life Costs		0.00
Life Cycle		**Life Cycle Costs over 40 year period including Construction Costs**		**£7,855,123.39**
		Annual Equivalent LCC Including Construction Costs (£/m²/annum)		**£96.36**
		Life Cycle Costs over 40 year period excluding Construction Costs		**£4,581,361.41**
		Annual Equivalent LCC excluding Construction Costs (£/m²/annum)		**£56.20**

Appendix 3

Calderdale Hub (Laura Mitchell) Project

			Staff Numbers	WTE	Desks
Dean Clough Total			**59**	**43.6**	**20.2**
Beechwood Medical Centre Total			**15**	**14.9**	**6.20**
Elmfield House Total			**44**	**37.1**	**13.7**
Brittania Works Total	**Adult Services**		**10**	**9.8**	**2.8**
Hebden Bridge Health Centre			**34**	**27.7**	**11.9**
The Dales Total			**30**	**26.2**	**8.2**
Savile Close Total			**19**	**17.50**	**7.80**
Broad Street Total	**Specialist Services**	**CAMHS**	**47**	**47**	**17.7**
			258	**223.8**	**88.5**



North

Site Plan
1 : 200

Rev P1 : 10.06.2014 :RMM : CL : Position of eastern block of building amended

Issue Purpose: Planning Application

P+HS Architects

The Old Station
Station Road
Stokesley TS9 7AB
01642 712684

Queens House
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Studio 14
Blackstock Mews
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Client	South West Yorkshire Partnership NHS Foundation Trust
Project	Calderdale Community Hub
Title	Proposed Site Plan
Issued From	Leeds
Date	April 2014
Scale	1 : 200 @ A1
Drawn	RMM Auth CL

Drawing Number: **2461 – D – 90 - 101** Revision: **– P1**

Stage Identification: Design - D Construction - C

Do not scale from this drawing. Work to figured dimensions, and any discrepancy to be reported to the Architect.

Refer to larger scale drawings where available. © P+HS Architects

South
1 : 100

metal louvred solar shading

curtain walling system with ceramic tinted spandrel panels (color to LPA approval)

aluminium frame /solar shading - dark grey (subject to LPA approval)

split faced architectural masonary - buff (subject to LPA approval)

curtain walling system with louvres to provide solar shading

through colour render finish (colour subject to LPA approval)

metal louvred solar shading

aluminium projecting frame / solar shading - dark grey (subject to LPA approval)

ground floor 'plinth', split faced architectural masonary - buff (subject to LPA approval)

site detailing, architectural masonary - buff (subject to LPA approval)

East
1 : 100

metal louvred solar shading

aluminium projecting frame / solar shading - dark grey (subject to LPA approval)

through colour render finish (colour subject to LPA approval)

site detailing, architectural masonary - buff (subject to LPA approval)

St James Court

existing sub station

Rev P6 : 10.06.2014 :RMM : CL : General amendments in line with revised GAs
Rev P5 : 04.06.2014 :RMM : CL : Cill height to FF windows amended.
Rev P4 : 02.06.2014 :RMM : CL : Annotation re finishes amended.
Rev P3 : 21.05.2014 :RMM : CL : Elevations split between two drawings for clarity.
Rev P2 : 13.05.2014 :RMM : CL : East line of building moved to minimise impact on Albion Court.
Rev P1 : 07.05.2014 :RMM : CL : Louvres added to external plant. Rear elevation amended. Site details added. General revisions / detail added.

Interserve

Issue Purpose: Planning Application

P+HS Architects

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P+HS architects

Client	South West Yorkshire Partnership NHS Foundation Trust
Project	Calderdale Community Hub
Title	Proposed Elevations
Issued From	Leeds
Date	April 2014
Scale	1 : 100 @ A1
Drawn	RMM
Auth	CL

Drawing Number: **2461 – D – 20 - 100** Revision: **– P6**

Stage Identification: Design - D Construction - C

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 24 June 2014
Agenda item 10

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 three times since the report to Trust Board in March 2014 in respect of: - a counterpart lease/licence to occupy Glen Acre House in Lindley, Huddersfield between the Trust and Calderdale and Huddersfield NHS foundation Trust; - a counterpart lease/licence to occupy Broad Street in Halifax between the Trust and Calderdale and Huddersfield NHS foundation Trust; and - Procure 21+ NEC3 contract in relation to multiple projects between the Trust and Interserve.
Recommendation:	**Trust Board is asked to note the use of the Trust's seal since the last report in March 2014.**
Private session:	Not applicable