With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (public session)
Tuesday 30 June 2015 at 9:00
Meeting room 1, Block 7, Fieldhead, Wakefield, WF1 3SP

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 28 April 2015

4. Assurance from Trust Board committees

4.1 Audit Committee 7 April and 22 May 2015
4.2 Clinical Governance and Clinical Safety Committee 21 April, 12 May and 16 June 2015
4.3 Mental Health Act Committee 12 May 2015
4.4 Remuneration and Terms of Service Committee 21 April 2015

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

6. Annual report, accounts and Quality Accounts 2014/15

7. Strategic human resources framework, including leadership and management development and staff engagement strategies

8. Performance report month 2 2015/16

8.1 Exception reporting and action plans

(i) Child and adolescent mental health services
(ii) Annual incident management report 2014/15
(iii) Customer services annual report
(iv) Health and safety annual report
(v) Sustainability strategy
(vi) Medical appraisal/re-validation annual report 2014/15

8.2 Performance report month 2 2015/16 (to follow)

8.3 Meeting the challenge and changes to Monitor's Risk Assessment Framework (to follow)

9. Corporate Governance Statement 2015/16

10. Use of Trust seal

11. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 21 July 2015 in the small conference room, Fieldhead, Wakefield, WF1 3SP.

Dates for 2016 (all Tuesday)
26 January
1 March
29 March
3 May
24 May
28 June
26 July
27 September
25 October
29 November
20 December

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
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 April 2015.
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 April 2015, 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. There is also a requirement for the Trust to assure itself that members of its Board meeting the fit and proper person requirements. Declarations made by new and existing Directors are included in the following paper.
Recommendation:	**Trust Board is asked to CONSIDER the attached declarations, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – Declaration of Interests
30 June 2015

The following declarations of interest were made by Directors.

Name	Declaration
CHAIR	
Ian Black	Chair representative, Mental Health Foundation Trust, NHS Providers' Board (from 1 July 2015) Removal (1 April 2015) Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management
NON-EXECUTIVE DIRECTORS	
Charlotte Dyson	Independent marketing consultant, Beyondmc (no clients engaged in NHS work) Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional) Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE
Chris Jones	Director, Chris Jones Consulting Ltd. Director and part-owner, Chris Jones Consulting Ltd. The business works primarily in the education and skills sector. Trustee, Children's Food Trust
CHIEF EXECUTIVE	
Steven Michael	Chair, Mental Health Network, NHS Confederation Trustee, NHS Confederation
OTHER DIRECTORS	
Kate Henry	No interests declared (although currently on secondment from NHS Improving Quality)

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

Minutes of Trust Board meeting held on 28 April 2015

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
Apologies:	Peter Aspinall	Non-Executive Director
	Helen Wollaston	Deputy Chair
In attendance:	Nette Carder	Interim District Service Director, CAMHS and Forensic Services
	Sean Rayner	District Service Director, Barnsley and Wakefield
	Diane Smith	Director of Health Intelligence and Innovation
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Service Director, Calderdale, Kirklees and Specialist Svcs.
	Bernie Cherriman-Sykes	Board Secretary (author)
Guests:	Emma Foreman	Senior Manager, Deloitte (observer as part of well-led governance review)
	Nadeem Ghana	Badenoch and Clark
	Hazel Walker	Governor, publicly elected, Wakefield

TB/15/23 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. There apologies, as above, were noted.

IB commented that this would be Peter Aspinall's last meeting as a Non-Executive Director following his retirement from Trust Board on 30 April 2015 after two full terms of office. He commended PA's contribution and support for the Trust and for the vast difference he made to the way the Audit Committee has offered scrutiny and monitoring of the Trust's governance arrangements, systems and processes. This provided a degree of rigour which has been enormously valuable. On behalf of Trust Board, he wished Peter well with a debt of gratitude for the real difference he has made.

TB/15/24 Declaration of interests (agenda item 2)

The following declarations were considered by Trust Board.

Name	Declaration
CHAIR	
Ian Black	Non-Executive Director, Benenden Healthcare (mutual) Non-Executive Director, Seedrs (with small shareholding) Private shareholding in Lloyds Banking Group PLC (retired member of staff) Chair, Family Fund (UK charity) Chair, Keegan and Pennykidd (insurance brokers) Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire

Name	Declaration
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	No interests declared
Laurence Campbell	Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council
Julie Fox	Currently on secondment to the Youth Justice Board; however, this is not likely to conflict with the non-executive director role
Jonathan Jones	Member, Squire Patton Boggs (UK) LLP Member, Squire Patton Boggs (MENA) LLP Spouse, Company Secretary, Zenith Leasedrive Holdings Limited and its subsidiaries Spouse, shareholder, Zenith Leasedrive Holdings Limited
Helen Wollaston	Director, Equal to the Occasion Ltd. (consultancy) Director, WISE, a (Women in Science and Engineering), a social enterprise promoting women in science, technology and engineering
CHIEF EXECUTIVE	
Steven Michael	Member of Huddersfield University Business School Advisory Board Member, Leeds University Centre for Innovation in Health Management Member, Leeds University Centre for Innovation in Health Management International Fellowship Scheme Partner, NHS Interim Management and Support Trustee, Spectrum People NHS Confederation elected Chief Executive representative, Mental Health Network Board Health and Wellbeing Boards, Wakefield and Barnsley Involvement in Care Quality Commission mental health inspection arrangements
EXECUTIVE DIRECTORS	
Adrian Berry	No interests declared
Tim Breedon	No interests declared
Alan Davis	No interests declared
Alex Farrell	Spouse is General Practitioner partner, City View Practice, Leeds
COMPANY SECRETARY	
Dawn Stephenson	Voluntary Trustee for Kirklees Active Leisure
OTHER DIRECTORS	
Nette Carder	Director, Athena Leadership and Management Limited
Sean Rayner	Member, Independent Monitoring Board for HMP Wealstun Trustee, Barnsley Premier Leisure
Diane Smith	No interests declared
Karen Taylor	No interests declared

There were no comments or remarks made on the Declarations, therefore, **it was RESOLVED to formally NOTE the Declarations of Interest by the Chair and Directors of the Trust.** It was noted that the Chair had reviewed the declarations made and concluded that none present a risk to the Trust in terms of conflict of interests. It was also noted that all Non-Executive Directors had signed the declaration of independence and all Directors had made a declaration that they meet the fit and proper person requirement.

TB/15/25 Minutes of and matters arising from the Trust Board meeting held on 31 March 2015 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 31 March 2015 as a true and accurate record of the meeting. There were no matters arising.

TB/15/26 Chair and Chief Executive's remarks (agenda item 4)

IB began his remarks by updating Trust Board on the process to recruit two new Non-Executive Directors to replace Peter Aspinall and Helen Wollaston. The process has been managed through an independent recruitment consultant (Penna) and began with a very successful awareness event in Wakefield in January 2015. The interviews were held the day before and the panel made up of IB as Chair, Michael Smith, publicly elected governor for Calderdale and Ruth Mason, appointed governor for Calderdale and Huddersfield NHS Foundation Trust as well as Stephen Winter (service user) and Carol Irving (carer). The panel interviewed six candidates and one candidate was found to be below the line. The panel recommended the appointment of three candidates to the Nominations Committee:

- Charlotte Dyson from 1 May 2015;
- Chris Jones from 1 August 2015; and
- Rachel Court from 1 September or 1 October 2015.

The Trust's Constitution allows for an additional Non-Executive Director (that is, six plus the Chair) and, given the calibre of the remaining candidates, the Nominations Committee approved the appointment of three candidates, rather than two, who will all bring something different and add value to Trust Board. This was thought to be particularly appropriate given the challenge and volume of work currently for Non-Executive Directors.

IB briefly outlined the rationale for appointing the three candidates. Charlotte Dyson was a very strong candidate and will bring a wealth of experience around marketing with strong commercial experience and skills currently missing from Trust Board arrangements. She also has previous experience as a Non-Executive Director in the NHS and will be the first 'starter' given Trust Board's current agenda. Chris Jones was a strong and thoughtful candidate and had very obviously researched the Trust. He was previously Chief Executive of Calderdale College, which he 'turned round' during his tenure to an outstanding OFSTED rating. He also brings experience of partnership working and has experience of mental health issues. Rachel Court will bring human resources and customer service experience and she also has Non-Executive Director experience at a building society and as Chair of the NHS Pensions Agency.

It was noted that ethnic diversity on Trust Board had not been addressed through these appointments and it was agreed that the Trust needs to do more to attract suitable candidates. It was noted that a number of applications were received but these were not of sufficient calibre to come through to interview stage.

IB also commented that he has put his name forward to sit on the NHS Providers Board as part of his objective to play a bigger role at national level.

IB also commented on the Board-to-Board meeting held with Locala as part of developing the partnership bid for Care Closer to Home in Kirklees. Jonathan Jones (JJ) asked what the implications would be for the Trust if the bid in partnership with Locala was unsuccessful. The Chief Executive (SM) responded that the commercial contractual risk is fairly minimal; however, strategically, an adverse outcome would diminish opportunities for the Trust to work with Locala on a wider footprint.

SM went on to cover the following in his remarks.

- The Trust's Care Quality Commission (CQC) inspection is unlikely to be in 2015; however, the Trust is maintaining its readiness and preparation activity. The Trust will receive 90 days' notice and the visit will involve a team of up to 100 over a week reporting within three months. Tim Breedon (TB) added that the focus for the Trust is on quality improvement rather than purely compliance and the visit will present an issue for

the Trust in terms of ensuring continuity of service delivery whilst undergoing such an intensive inspection. SM added that Trust Board's decision to undertake the well-led review now will support the CQC inspection.

- The Trust is a partner in three Vanguard bids, a national initiative to pilot and promote new models for delivery of care, two in Wakefield and one in Calderdale and the Trust's focus will be to ensure integration and inclusion of mental health.
- GP communities.
- Mental health developments nationally.

TB/15/27 Audit Committee annual report to Trust Board 2014/15 (agenda item 5)

It was RESOLVED to RECEIVE the annual report from the Audit Committee and to SUPPORT the view that the Committee can provide assurance that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that Committees meet the requirements of their Terms of Reference, Committee workplans are aligned to the risks and objectives of the organisation within the scope of their remit and Committees can demonstrate added value to the organisation.

TB/15/28 Strategic overview of business and associated risks (agenda item 6)

SM explained that the paper set out a general overview of the Trust's position and associated risks with cross-reference to the organisational risk register. It demonstrates clearly what a volatile environment the Trust is operating in and Trust Board understanding of risk, the Trust's service offer and how and where its key partnerships are.

JJ commented that this emphasises the difficult environment the Trust operates in and how challenging this is. Transformation and the effective and efficient use of estate and technology are key to ensuring the Trust remains viable and sustainable. Alan Davis (AGD) commented that this should also include other forms of technology, such as advances in medicines and pharmaceuticals, and how these could impact on Trust services or that the Trust could lead on. TB commented that the paper also demonstrates the level of complexity and amount of time expended to maintain and enhance the Trust's position, particularly at senior level.

Trust Board confirmed that the risks presented were appropriate and relevant. Julie Fox (JF) asked if Barnsley should be added to the risk around child and adolescent mental health services. Nette Carder (NC) responded that the risk currently refers to particular circumstances in Calderdale and Kirklees. Other areas do not carry such a significant level of risk to escalate to the organisational risk register; however, this position will be monitored closely by the Clinical Governance and Clinical Safety Committee.

TB/15/29 Assurance framework and risk register (agenda item 7)

IB asked whether there were any gaps in control that concerned the Executive Management Team (EMT) more than others. Dawn Stephenson (DS) responded that it would be clinical record keeping and IB suggested a paper to July's Trust Board and discussion at the Clinical Governance and Clinical Safety Committee in June to inform the Trust Board paper and discussion.

It was RESOLVED to NOTE the assurances provided for Q3 of 2014/15, NOTE where gaps in assurance have been identified through the Trust-wide risk register and NOTE the key risks for the organisation.

TB/15/30 Performance reports month 12 2014/15 (agenda item 8)

TB/15/30a Quality performance report (agenda item 8.1)

TB highlighted the following.

- The Clinical Governance and Clinical Safety Committee had asked for clarification of the discrepancy in ethnicity coding between the Quality Accounts and analysis reported to the Mental Health Act Committee. TB explained that the Quality Accounts measure includes 'not known' responses, which the Trust is working to eliminate and ensure ethnicity is recorded.
- The Trust has undertaken a retrospective review of the use of restraint and seclusion in August 2014 and confirmed that this month was an outlier due to extreme pressures across the system at the time. Figures since have been in line with expectations but the position will be carefully monitored.
- The Trust has introduced a pilot education programme for police officers in Calderdale and Kirklees on mental health services and police liaison posts are now in place. This supports the Trust's partnership work in relation to the Mental Health Crisis Concordat. SM added that mental health provider Chief Executives in West Yorkshire met with the Chief Constable and Police and Crime Commissioner for West Yorkshire to discuss the partnership approach and there has been a subsequent discussion with the Yorkshire Ambulance Service. It is hoped to replicate the discussions and arrangements in South Yorkshire.
- Trust Board noted the change at national level in the serious incident framework to remove grading of incidents and introduce a single timescale of 60 working days for reporting. JF commented that she would like to see the Trust continue to aim for the current 45 days for the benefit of the service users and their families. TB confirmed that the Trust would continue to work to the 45 days as the rule and 60 days as the exception.
- Trust Board also noted that the Clinical Governance and Clinical Safety Committee had suggested that the Trust's approach to enabling service users into employment is included in the remit of the new Equality and Inclusion Forum.

Alex Farrell (AF) added that she is reviewing the performance framework with Directors to reflect revised objectives and related key performance indicators for introduction and reporting at the end of Q1. The Trust will look at the practice of other sectors and design principles would be welcome from Non-Executive Directors to inform development.

Financial position

AF then took Trust Board through the key points relating to the Trust's financial position.

- The Trust has achieved a financial risk rating of 4 against a planned rating of 4.
- The outturn position for 2014/15 is a net surplus of £3.1 million, which is £0.5 million ahead of plan.
- The income position has improved, mainly due to better CQUIN achievement than anticipated (£100,000 against forecast £500,000), lease cars and Altogether Better.
- There has been a significant underspend in pay, which was £3.4 million at the year-end. The EMT, supported by the Operational Requirement Group, asked for a detailed analysis to understand the reasons for this and any impact on quality and safety. No issues with service quality were identified; however, this will be monitored closely during 2015/16.

- Additional investment in information management and technology was made non-recurrently.
- Provisions have increased to £2.4 million, of which £2.1 million is provided for redundancies.
- The capital spend to March 2015 is £6.13 million, which is £1.93 million (24%) behind the revised plan. JJ commented that Trust Board agreed in March 2015 to monitor and scrutinise the capital programme in the same way it does the cost improvement programme. SM confirmed that the finance report will include a one-page summary tracking capital spend and investment for Trust Board from month 2. AF added that, for other Trusts, spend on the capital programme will reflect the availability of cash, which affects the ability to spend capital.

Laurence Campbell (LC) commented that debtors are higher than planned. AF responded that the main factor is with local authorities and, as their funding forms a bigger proportion of Trust income, it has a larger effect on debtors.

Workforce

AGD commented that the Remuneration and Terms of Service Committee reviewed the workforce indicators in detail at its meeting in April 2015 with particular focus on child and adolescent mental health services. The sickness target has not been achieved but does still compare well with other Trusts. The Committee has agreed to review the target for 2015/16.

TB/15/30b Customer services report quarter 4 2014/15 (agenda item 8.2)

IB asked if the Trust could look at its approach from a carer's point of view, particularly in terms of data protection, carer access to information and confidentiality of service user information. He suggested that the Trust should be able to explain its position in a better way that it currently does, which sounds legalistic and defensive. Adrian Berry (ABe) responded that this is a very complex area with competing views between services users and carers. Legislation and the frameworks within which the Trust is required to work are very clear; however, more could be done to support services to explain why information cannot be shared and how this message is delivered to carers.

ABe also highlighted the significant improvement in the number of compliments in forensic services over the last two quarters.

TB/15/30c Exception reports and action plans – Child and adolescent mental health services recovery plan – progress report (agenda item 8.3(i))

TB and NC took Trust Board through the update paper.

JJ asked for a view of the outcome of a CQC assessment currently. SM responded that it would be one of 'requires improvement'. Trust Board reiterated its position stated in March 2015 that, if there is no substantial change to the current situation, the position is unsustainable without further investment. This will be discussed further at the summit on 8 May 2015 and the Trust will work with commissioners to come to a joint solution; however, if this is not forthcoming, Trust Board will have to consider whether the Trust can continue to deliver the service.

JJ commented that his fear is that NHS inertia will delay any decision and that this inertia would have to come to an end on 1 April 2016 when the Trust's current contract comes to an end. IB asked for an update at the May strategic meeting for Trust Board to consider the outcome of the summit and agree any action required in advance of a formal update to June's meeting.

JF commented that the number of referrals is increasing and asked that the Trust continues to monitor this. IB added that any other issues Trust Board would wish to see raised at the summit on 8 May 2015 should be passed to TB.

AF commented that there have been discussions on how the business case could be funded and she was confident that the Trust could manage the investment in the interim to make it sustainable through additional development money. SM added that there is an increased focus nationally on mental health and, in particular, children's mental health services to support the Trust's position.

It was RESOLVED to NOTE the progress report.

TB/15/30d Exception reports and action plans – Risk assessment of performance and compliance targets 2015/16 (agenda item 8.3(ii))

IB asked if commissioners budgeted to award the CQUIN payments as inconsistencies between providers and commissioners would be an issue at NHS aggregate level. AF responded that guidance states that CQUINs should be set at a level that is stretching but achievable; commissioners should, therefore, budget accordingly. She also confirmed that CQUINs are in the Trust's contracts and in commissioners' budgets.

It was RESOLVED to NOTE the risk assessment and actions to mitigate risk.

TB/15/30e Exception reports and action plans – Trust visit programme annual report 2014/15 (agenda item 8.3(iii))

The following points were raised and discussed.

- AF asked if there was any evidence of progress or triangulation in relation to the quality of record keeping and care planning as it would be useful to identify areas of best practice for services to learn from. ABe also suggested matching areas of best practice with areas where practice could be improved.
- AGD suggested including information on the outcome of the staff wellbeing survey and friends and family test in the information pack for visit teams.
- IB was keen that the programme in 2015/16 includes governors. TB responded that members of the team require a level of technical understanding and he would see governors as making an effective contribution to the 15 Steps Challenge process. SM commented that the inclusion of governors brings a broader perspective to the visit teams and IB added that he wished to see governors explicitly included in the coming year.
- JF commented that the Trust cannot know whether its benchmark is that of the CQC. She suggested that an external review might be useful but not on the scale of the full inspection arrangements.

It was RESOLVED to NOTE the report and SUPPORT the Trust visit plan for 2015/16.

TB/15/30f Exception reports and action plans – Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation (agenda item 8.3(iv))

SM commented that the paper sets out a sensible response to the review, particularly of where decisions can be taken within the organisation fostering flexibility and a timely approach to decision-making, particularly in areas such as recruitment.

It was RESOLVED to APPROVE the approach and timetable for reviewing the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

TB/15/31 Strategies for approval (agenda item 9)

TB/15/31a Patient Safety Strategy and Sign up to Safety improvement plan (agenda item 9.1)

AF commented that the Strategy will be cross-referenced to the development of the performance framework.

It was RESOLVED to APPROVE the Patient Safety Strategy, to NOTE the Trust's Sign up to Safety improvement plan and APPROVE the submission of the plan for review and feedback.

TB/15/31b Leadership and Management Development Strategy update (agenda item 9.2)

Asked for a BDU perspective, Sean Rayner (SR) commented that there is evidence that some developments are moving at pace, such as the establishment of trio arrangements, and that these are beginning to impact favourably on services. Karen Taylor (KT) added that deputy BDU directors are working together as a cohesive team and work well with trios as evidenced in the independent report on the Trust's financial plan and how it was developed. AF added that Quality Academy deputies are offering an integrated offer to BDUs.

Linked to the previous item, SR added that the review of the Standing Financial Instructions and Scheme of Delegation should be much more than a technical review and it is important to match decision-making and empowerment across the organisation at all levels.

It was unanimously RESOLVED to NOTE the update on development of the Strategy and to have a more detailed discussion at the strategic meeting in May 2015.

TB/15/32 Annual Governance Statement 2014/15 (agenda item 10)

It was RESOLVED to APPROVE the Annual Governance Statement for 2014/15. It was noted that the Statement may be subject to change following review by the Trust's external auditors as part of the audit of the Trust's annual report and accounts. **It was, therefore, RESOLVED to DELEGATE AUTHORITY to the Audit Committee to approve the final version of the Statement.**

TB/15/33 Trust Board self-certification – Monitor quarter 4 return 2014/16 (agenda item 11)

AF informed Trust Board that an internal audit report on data quality identified anomalies within the early intervention services target. Given this was a small sample, the EMT commissioned a full review of the caseload to ensure reporting against the target. Monitor and Non-Executive Directors will be informed of any implications for the Trust as a result of the detailed review. She assured Trust Board that this was not a contracting issue.

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

TB/15/34 Date and time of next meeting (agenda item 12)

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

Signed …… Date ……

Trust Board 30 June 2015
Agenda item 4 – assurance from Trust Board Committees

Audit Committee

Date	7 April and 22 May 2015
Presented by	Laurence Campbell
Key items to raise at Trust Board	➢ Data quality ➢ Audit Committee annual report (presented to Trust Board 28 April 2015) ➢ Deloitte progress report ➢ Reference costs ➢ Internal audit 'grading' ➢ Addition of 'culture' to the internal audit programme ➢ Approval of annual report, accounts and Quality Accounts for 2014/15 (Trust Board agenda item 6)

Clinical Governance and Clinical Safety Committee

Date	21 April, 12 May and 16 June 2015
Presented by	Helen Wollaston
Key items to raise at Trust Board	➢ Approval of Quality Accounts 2014/15 (Trust Board agenda item 6) ➢ Child and adolescent mental health services ➢ Presentation of Pharmacy Strategy ➢ Serious incidents annual report (Trust Board agenda item 8.1(ii) ➢ Review of Horizon Centre ➢ Transformation – rehabilitation and recovery services

Mental Health Act Committee

Date	12 May 2015
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Consent to Treatment audit ➢ New Mental Health Act Code of Practice

Remuneration and Terms of Service Committee

Date	21 April 2015
Presented by	Ian Black
Key items to raise at Trust Board	➢ Leadership and management development strategy ➢ Continued monitoring of sickness absence performance ➢ Directors' performance related pay scheme ➢ Clinical Excellence Awards

Minutes of Audit Committee held on 7 April 2015

Present:	Peter Aspinall	Non-Executive Director
	Laurence Campbell	Chair of the Committee
	Jonathan Jones	Non-Executive Director
Apologies:	Members	
	None	
	Others	
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Paul Thomson	Partner, Deloitte
In attendance:	Rob Adamson	Head of Finance
	Tim Breedon	Director of Nursing, Clinical Governance and Safety (to item 5 and part item 7.1)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Jon Cohen	Manager, KPMG (Local Counter Fraud Specialist)
	Tony Cooper	Head of Procurement
	Mark Dalton	Manager, KPMG
	Alan Davis	Director of Human Resources and Workforce Development (to item 5 and part item 7.1)
	Julie Fox	Non-Executive Director
	Paul Hewitson	Director, Deloitte
	Debbie Hogg	Deputy Director of Finance
	Clare Partridge	Director, KPMG (Head of Internal Audit)
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Service Director, Calderdale and Kirklees (to item 6 and item 7.1)

AC/15/22 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (LC) welcomed everyone to the meeting. The apologies, as above, were noted. On behalf of the Committee, LC thanked Peter Aspinall (PA) for his support and contribution to the Audit Committee during his period as Chair and wished him well for the future when his term of office ends on 30 April 2015.

AC/15/23 Minutes of the meeting held on 20 January 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 20 January 2015 as a true and accurate record of the meeting.

AC/15/24 Matters arising from the meeting held on 20 January 2015 (agenda item 3)

There were three matters arising.

AC/15/11 Annual penetration testing of IT systems

Debbie Hogg (DH) updated the Committee on the response to the issue raised by PA from Adrienne Pickering, Deputy Director of IM&T.

As standard, the Trust carries out annual penetration (PEN) tests on the Trust's IT systems. Taking into consideration the number of changes to the existing IT infrastructure through the transition to a new IT support supplier in 2014, the decision was taken that no PEN testing would be commissioned in 2014; however, as soon as transition work is complete, then PEN

testing will be scheduled. The contract with Phoenix identifies that the Trust requires PEN testing to be performed annually and Phoenix will have to support this process.

In 2013 penetration testing was performed on the Trust's clinical information system (RiO). This test was carried out by an independent CHECK accredited PEN testing provider. The results of this test highlighted a number of security issues around the RiO application and its hosting arrangements, which have subsequently been addressed by the system supplier. A second PEN test of the RiO platform will be carried out once Version 7 of the application is in place (estimated timescale July 2015). In addition, the Trust will schedule testing of all internet facing Trust IT services following the transition to Phoenix, including LYNC2013, Outlook Web Access, Outlook Mobile Access, the VPN platform and guest wireless internet access.

PA asked if there had been an assessment of the Trust's exposure in the meantime and LC asked if there were any processes that could be applied to provide additional assurance in the interim, such as an internal or external audit perspective. Clare Partridge (CP) commented that KPMG would be happy to consider such a review as part of the internal audit plan for 2015/16 and will raise this with Alex Farrell (AF).

Action: Clare Partridge/Alex Farrell

AC/15/14 Infection prevention and control internal audit

Tim Breedon (TB) informed the Committee that the re-tendering process had been delayed by commissioners and, therefore, the Trust had delayed its action in response to the internal audit recommendation until the service specification is confirmed. The Trust has set a deadline of six months for a resolution to the position.

AC/15/15 Counter fraud

A response to the issues raised at the last meeting was included in the action points paper circulated with papers for the meeting.

AC/15/25 Audit Committee annual report to Trust Board and presentation of risk Committees' annual reports (agenda item 4)

The Audit Committee received the annual report, terms of reference and forward work programmes from each Committee. Each was supported by a short presentation from Julie Fox (JF), Chair of the Mental Health Act Committee, who also presented on behalf of the Chair of the Clinical Governance and Clinical Safety Committee (Helen Wollaston), and Alan Davis (AGD) on behalf of the Chair of the Remuneration and Terms of Service Committee (Ian Black). 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 – Laurence Campbell; Lead Director – Alex Farrell

The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation.

It was noted that, in January 2015 at the request of the Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. The Committee compared well against best practice and a number of actions were identified by the Company Secretary for further development. These have been agreed with the Chair of the Committee and included a small number of suggested revisions to the terms of reference. The Chair of the Committee asked for a review of the existing terms with recognised best practice (Healthcare Financial Management Association Audit Committee Handbook and

NHS Providers Foundations of Good Governance). The existing terms of reference were found to be fit for purpose against both and it was agreed to consider the points raised during the coming year following wider discussion and consultation with the Chair of the Trust.

LC commented that he and PA collectively had attended meetings of all Committees during the year and he suggested that it would be worthwhile for other Non-Executive Directors to do the same. He also commented on the major piece of work to re-tender external audit services and the extension of the contract for internal audit.

Paul Hewitson (PH) commented that the Trust is required to report the risks raised by external audit in its annual report and he suggested that the best place to do this would be the Audit Committee's annual report. He also suggested that consideration of the non-audit work of the auditors is included in the Committee report.

Clinical Governance and Clinical Safety Committee

Chair – Helen Wollaston; Lead Director – Tim Breedon

The Committee met its Terms of Reference and continued to develop its work programme throughout the year to reflect the risks and objectives of the organisation. Scrutiny of progress to meet the recovery plan for child and adolescent mental health services is a standing item on the Committee's agenda and will remain so through 2015. Progress is slower than expected but the Committee is assured that action is in place and, in particular, welcomed the appointment of an interim BDU Director for the service with whom non-executive director links have been made. JF went on to comment that the Committee's focus for the coming year will be on improvement and this is reflected by the ongoing scrutiny of the Trust's approach to the transformation of its services. Presentations on learning disability services, dementia and recovery have been received to date.

Mental Health Act Committee

Chair – Julie Fox; Lead Director – Tim Breedon

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

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

LC commented on the comment in the Committee's self-assessment that links with the Audit Committee could be stronger. JF responded that she would like to see any items pertinent to the Committee passed on to the Committee Chair. It was suggested that sight of the agenda would be helpful.

Action: Bernie Cherriman-Sykes

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. AGD raised the following.

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

As a member of the Committee, Jonathan Jones (JJ) commented that the detailed review of HR performance areas was particularly useful.

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**.

PA asked what assurance the Committee has that Directors' objectives reflect Committee and Trust Board concerns and have the necessary management focus. He asked whether assurance Committees have access to the criteria and objectives set for Directors. AGD responded that the corporate objectives are agreed by Trust Board and corporate/gateway objectives approved by the Remuneration and Terms of Service Committee focus on key organisational aims and objectives. Individual Director objectives are agreed with the Chief Executive and reported back to the Remuneration and Terms of Service Committee. LC suggested also taking through the Audit Committee and Trust Board. Dawn Stephenson (DS) responded that the Committee needs to be sure that Committees do not duplicate action. JJ commented that assurance was received through the relevant Committee (that is, the Remuneration and Terms of Service Committee) and that this is reported into Trust Board. His view, therefore, is that systems are in place and there is no need for further assurance. PA accepted the view and commented that Trust Board must be assured that Committees have the opportunity to influence objectives to ensure these reflect priorities and risks identified by Committees. It was agreed this should be discussed further with the Chair of the Trust.

Action: Laurence Campbell

LC asked for the Committee's view of the 'training' activity undertaken during 2014/15. JJ commented that he found it very useful. PA added that benchmarking and comparison with others was helpful. The Committee generally agreed that the 'training' should not be

prescriptive and should focus on gaps in knowledge or areas of interest for the Committee and internal and external audit should be encouraged to advise as appropriate. It was also suggested that the 'training' should be opened up to all members of Trust Board.

AC/15/25 Service line reporting (agenda item 5)

Karen Taylor (KT) took the Committee through the key points of her presentation and provided examples of utilisation, benefits and plans for further application. The Committee agreed it would find it useful to have a visualisation of how different services/service lines perform in terms of service line reporting. LC suggested a two-by-two visualisation showing the strong and weak contributors plotted against their growth potential or size and it was suggested that the presentation of work done for the Executive Management Team (EMT) could be adapted for Trust Board.

Action: Alex Farrell

AC/15/26 Annual accounts progress, including draft audit opinion (agenda item 6)

PH took the Committee through the report in relation to the financial statements audit, the Quality Accounts limited assurance opinion and annual reporting disclosures. The Committee was content with the format and wording of the draft audit opinion. The Committee also noted the section on sector developments, benchmarking, which shows the Trust is performing well comparatively, and the responsibility statement.

The Committee also noted that Deloitte has been appointed as the independent reviewer for the well-led governance review and assurance had been provided on the review team's independence, with which the Trust was content. This view was supported by the Committee.

AC/15/27 Internal audit progress report (agenda item 7)

Progress report (agenda item 7.1)

CP introduced this item. The draft Head of Internal Audit Opinion, which covers core areas of financial controls and governance assurance, anticipates an opinion of significant assurance with minor improvement opportunities.

Mark Dalton (MD) took the Committee through the progress report. Five reports had been issued since the last Committee:

- payroll, including data analysis, which received significant assurance with minor improvements;
- bed management, which received partial assurance with improvements required;
- Quality Improvement Strategy, which received significant assurance with minor improvement opportunities and partial assurance with improvements required for data quality;
- information governance toolkit phase 2, which received significant assurance with minor improvement opportunities; and
- patient experience and engagement phases I and II, which received significant assurance with minor improvement opportunities.

PA asked what the drivers were for a Head of Internal Audit Opinion of 'significant assurance with minor improvement opportunities'. CP responded that her judgement as Head of Internal Audit is that core controls and operations are good with some recommendations as the Trust would expect. There are some areas that are pulling the Trust down but not

sufficiently to lower a significant assurance opinion. Areas where the Trust has already identified risk and has sought the independent opinion of internal audit moves the Trust from 'no assurance' to 'partial' on individual internal audit reports. LC commented that he was unsure that the scoring system has sufficient breadth and asked if there could be more structure. CP responded that there has to be a judgement of how fundamental and important an area of risk is for the Trust and there would be a caveat if an area received a 'no assurance' opinion but presented no significant risk to the Trust. The rating system could be developed further to suit the Trust.

Quality Improvement Strategy/data quality

The Committee noted that the opinion for the Quality Improvement Strategy/data quality review was divided into two parts:

- significant assurance with minor improvement opportunities for the Quality Improvement Strategy; and
- partial assurance with improvements required for data quality.

CP and MD summarised the findings from the report. Management action has been agreed for each recommendation included in the report (one high, three medium and three low).

Three indicators were selected in consultation with the Trust and these reflected areas of risk already identified by the Trust. TB reiterated the Trust's wish to improve and, therefore, it had identified areas it saw as high risk. The Trust's position replicates system-wide issues with interpretation of indicators and, therefore, it was important to seek clarity and test guidance for staff. Much work has been done with IM&T to ensure recording mechanisms are robust, simple and clear, and that there is clear guidance with no room for misinterpretation of action required of staff. This is monitored through the Data Quality Steering Group, chaired by TB. TB added that the 'trio' arrangements will make a clear difference and improvement at service line level and evidence that this is happening is beginning to be seen.

PA wanted to understand more about the role of the Data Quality Steering Group and what it is achieving. TB responded that it was set up in response to system issues and to ensure the Trust's response and improvement activity is clinically-led. Each BDU has a data quality improvement plan with parameters and trajectory set by the Group. There have been obvious improvements over the last 18 months and it is only really challenging areas that now remain; hence, the support sought from internal audit to help drive forward improvement.

JJ asked if there were any further indicators with the same issues. TB responded that it was not evident; however, some may emerge as a result of transformation, such as access, which will be monitored and robustly reviewed. He assured the Committee that this remains high on the Trust's agenda. He added that the outcome of the General Election might also impact on some indicators.

JF asked how the Trust will know it has improved. TB responded that this would be through internal review as part of the quality assurance processes through practice governance and through internal audit in 2015/16. MD added that there will be a follow up of recommendations as part of routine work and review of performance indicators in 2015/16.

Bed management

MD took the Committee through the findings of the audit. The recommendations (one high, three medium and one low) had been accepted by management and management action was included in the report. KT commented that this was an area identified by the Trust as an area for development and improvement and, therefore, the report findings were very

helpful. She was confident that the Trust can move forward and improve its operational response.

The tracker report and technical update were noted.

Annual plan 2015/16 (agenda item 7.2)
LC commented that he would like to see assurance and risk analysis of organisational culture, values and behaviours, and how these could be 'measured' and 'audited', particularly in terms of how Trust values are reflected and embodied by staff throughout the organisation. Middle management was a particular area for focus. CP responded that she would consider use of a KPMG tool and how this could be utilised to support the Trust. DS added that the outcome of the well-led review might indicate that this is an area for focus.

JF added that she would like to see equality and diversity considered as part of audits, where appropriate.

It was RESOLVED to APPROVE the internal audit plan for 2015/16, subject to consideration of the point above. The internal audit protocol was noted.

AC/15/28 Reference costs (agenda item 8)

On behalf of Trust Board, the Committee was asked to confirm a number of statements in relation to the costing process to support the reference costs submission. PA asked for further assurance regarding data quality. DH responded that the statements refer to the calculation of reference costs covering Trust activity. The internal audit review refers to specific performance indicators. Capita reviewed the Trust's methodology and the approach the Trust has taken.

Both PA and LC were concerned at the apparent mis-match between assurance on the robustness and quality of data used to form the reference costs and the outcome of the internal audit on data quality. DH and KPMG both explained that the internal audit reviewed specific KPIs in very discrete areas and not the compilation of reference costs (which has been independently reviewed by Capita). The comments on data quality from KPMG as a result of this are at the margins not across the whole of the Trust's activity. JJ commented that he was assured and understood there was a clear difference. LC concurred. PA ended by commenting that, if the issues regarding data quality are not materially related to conglomerated figures, he would accept the recommendations in the paper; however, given what had been reported at the meeting, he remained uncomfortable in providing assurance to Trust Board. LC asked DH to review the issues raised with AF and respond to the concerns with a view to resolving prior to Trust Board.

Action: Debbie Hogg

AC/15/29 Currency development (agenda item 9)

DH provided an update on currency development and the Trust will continue shadow reporting during 2015/16.

AC/15/30 Triangulation of risk, performance and governance (agenda item 10)

The report was noted.

AC/15/31 Treasury management update (agenda item 11)

The report was noted.

AC/15/32 Counter fraud progress report (agenda item 12)

Progress report (item 12.1)

Jon Cohen (JC) took the Committee through the report and activity since the last meeting. The report and technical update were noted. Progress against the recommendations made in the NHS Protect qualitative assessment was noted.

Annual plan 2015/16 (item 12.2)

It was RESOLVED to APPROVE the counter fraud annual plan for 2015/16.

AC/15/33 Procurement report (agenda item 13)

Tony Cooper (TC) took the Committee through his report.

CP observed that this Trust has more single source tenders than other Trusts. There seemed to be no obvious reason for this but it could be related to financial thresholds, which will be reviewed as part of the benchmarking exercise.

AC/15/34 Losses and special payments report (agenda item 17)

The report was noted.

AC/15/35 Items to report to Trust Board (agenda item 15)

These were agreed as:

- data quality;
- Audit Committee annual report;
- Deloitte progress report;
- reference costs;
- internal audit 'grading'
- addition of 'culture' to the internal audit programme.

AC/15/36 Date of next meeting (agenda item 16)

The next meeting will be held on Friday 22 May 2015 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield, to approve the annual report and accounts, and then on Tuesday 7 July 2015 at 14:00 in rooms 49/50, Folly Hall, Huddersfield.

AC/15/37 Any other business (agenda item 17)

No other business was raised.

Minutes of Audit Committee held on 22 May 2015

Present:	Laurence Campbell	Non-Executive Director (Chair of the Committee)
	Jonathan Jones	Non-Executive Director
Apologies:	Members	
	None	
	Others	
	None	
In attendance:	Rob Adamson	Head of Finance
	Ian Black	Chair of the Trust
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Mark Dalton	Manager, KPMG
	Alan Davis	Director of Human Resources and Workforce Development
	Charlotte Dyson	Non-Executive Director
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Paul Hewitson	Director, Deloitte
	Steven Michael	Chief Executive
	Dawn Stephenson	Director of Corporate Development
	Paul Thomson	Partner, Deloitte

AC/15/40 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (LC) welcomed everyone to the meeting.

AC/15/41 Minutes of the meeting held on 21 April 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 21 April 2015 as a true and accurate record of the meeting. Matters arising will be taken at the meeting on 7 July 2015.

AC/15/42 Consideration of the annual accounts for the period 1 April 2014 to 31 March 2015, including the charitable funds accounts for the same period (agenda item 3)

It was noted that charitable funds were included in the Trust's accounts as part of the consolidated group accounts.

Report from the Director of Finance on the accounts (agenda item 3.1)

Alex Farrell (AF) took the Committee through her report as Director of Finance. She thanked the finance team for their work to prepare the accounts.

Charlotte Dyson (CD) asked why capital expenditure was less than last year. AF responded that there had been several reports to Trust Board and to Monitor explaining that the Trust would not meet its capital plan for 2014/15. The underspend was primarily caused by planning permission delays and other building issues with the community hub in Calderdale, and the inability to identify a suitable site for the development of a hub in Wakefield.

Ian Black (IB) commented that, in the coming year, Trust Board will monitor capital expenditure and investments in the same way as it undertakes detailed scrutiny of the cost improvement programme.

CD went on to ask why the inventory had reduced. AF responded that this relates to community equipment and changes in the levels deployed and retained in stock. CS also asked what constituted intangible assets and AF responded that this referred to software licences. AF also confirmed that the Trust robustly monitors the effect of redundancies on patient care. CD asked if this was covered from a reputation point of view. The Chief Executive (SM) responded that most redundancies in 2014/15 were in back office/support functions to protect front-line staff and the Trust's quality impact assessment process includes the impact of redundancies.

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

Head of Internal Audit Opinion 2014/15 (agenda item 3.2)

In introducing this item, Mark Dalton (MD) commented that the Opinion was consistent with the draft presented to the Committee in April 2015 providing significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Opinion was based on thirteen audits completed in the period, which included core financial processes. Both audits on the Board assurance framework and corporate governance arrangements received significant assurance. Four audits receive partial assurance. All were reported to and discussed at the relevant Committee meeting. There were no issues in the audits receiving a partial assurance opinion or in the high priority recommendations that prevented the issue of a significant assurance Opinion.

IB asked how good the Trust is at meeting timescales. MD responded that this is a standard report to the Audit Committee and, generally, the Trust responds well and meets timescales. For one audit in relation to patients' property, the majority of recommendations have been implemented but there are some outstanding areas and these will be discussed with the Committee in July 2015.

LC asked for clarification of the relationship with external audit given there was no rating for the performance indicator for "reliance external audit place on work". MD responded that there would be more detailed dialogue if internal audit was reporting concerns on financially-related issues. Where appropriate, internal audit co-ordinates with external audit but there is limited reliance given the Trust's position.

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

Report to the Audit Committee on the audit for year ended 31 March 2015 (agenda item 3.3)

Paul Thomson (PT) introduced this item on behalf of Deloitte and commented that this was the fifth year Deloitte had undertaken the audit. He added that this had been a good audit and the co-operation of Trust staff was good. The process in place was very good and Deloitte appreciated the support from the Trust. The Trust is in an excellent position compared to other Trusts in the north, which is a credit to the finance team. There are a number of adjustments, mostly misjudgements or extrapolation, with few errors.

Paul Hewitson (PH) advised the Committee that all items outlined on page 4 of the report were now complete with the exception of the review of events since 31 March 2015 and receipt of the Letter of Representation. Deloitte was, therefore, in a position to conclude its audit. He then took the Committee through the detail.

The agreement of balances exercise has shown a discrepancy with income received from NHS England. NHS England has been asked for an explanation but no response has been received; therefore, there is a prospect that the income figure could be wrong.

The Committee noted the comments regarding Laura Mitchell House and the treatment of cost of acquisition and demolition amounting to £116,000. This was not considered to be material but has been included in the aggregation of small errors. It was noted that it is the Trust's practice to wait until a building is commissioned before writing-off any charges. IB asked the Committee to look at the process at its next meeting.

Action: Alex Farrell

There were no concerns raised in relation to value for money.

With regard to the provision for VAT in relation to HMRC guidance on VAT recovery, the Trust was invited to adjust its accounts and its view was that this is immaterial and the accounts should not change. The Committee supported this view.

PH ended by commenting on the co-operative environment of the Trust in response to comments and observations, which is not seen elsewhere. He thanked and recognised the efforts of the finance team, particularly in the face of capacity issues.

Letter of Representation (agenda item 3.4)
PH highlighted two clauses specific to the Trust. The first is in relation to an accrual made for the cost of performance related bonuses as the outcome is not yet known. The second relates to the Trust's view that it only has one operating segment. Deloitte reviewed the evidence and considers this to be a single segment disclosure.

It was RESOLVED to APPROVE the Letter of Representation.

Approval of annual accounts and FT consolidated schedules (agenda item 3.5)
Based on the presentation and discussion under previous sections of this item, **it was RESOLVED to APPROVE the accounts for 2014/15.**

AC/15/43 Approval of annual report 2014/15 (agenda item 4)

Dawn Stephenson (DS) alerted the Committee to a number of minor changes to the report since its inclusion in the papers and, in particular, the Chair and Chief Executive's introduction.

It was RESOLVED to APPROVE the annual report and the Annual Governance Statement for 2014/15.

AC/15/44 Approval of quality report 2014/15 and auditor's report on the quality accounts (agenda item 5)

Tim Breedon (TB) commented that it is an ongoing challenge to meet the requirements of the reporting framework and to develop a meaningful and understandable document. He added that the report provides a snapshot of Trust arrangements and it is not intended to fully cover all quality issues and initiatives.

Four responses were received from stakeholders and partners and these were helpful and constructive. There was also support from the Members' Council and this year's process had provided for a richer discussion, which was more proactive in nature.

IB asked for TB's view of the comment by Calderdale, Kirklees and Wakefield Clinical Commissioning Groups in relation to the review of NICE clinical quality standards. TB responded that the Trust reports regularly on NICE to the commissioners' Quality Board and

the Trust was, therefore, unsure of the basis for the comment. The Trust is currently in dialogue with commissioners so the comment may change.

IB also remarked on the comment in relation to the challenges faced by child and adolescent mental health services in Calderdale and Kirklees. He was of the opinion that the report must reflect the issues the Trust faces but be balanced given this was only one part of the services the Trust provides and he felt that the report did this. He was also pleased that the Members' Council had been actively engaged and there had been challenge from governors, which was very helpful. It was noted that this approach is not really replicated in other Trusts.

CD asked if the Trust has the right systems and processes in place in relation to data reporting. TB responded that there has been a significant improvement over the last year; however, some challenges remain to ensure staff understand the benefits and relevance of good record-keeping. AF added that further improvement will be supported by optimisation of the Trust's clinical information system, RiO, with the upgrade to version 7, engagement with clinical staff to fully understand what is required of the system, ensuring the design of the system is right, and that staff are appropriately skilled. The level of investment is appropriate with engagement as the area for development.

PT commented that the limited scope Opinion includes a review of the report and its disclosures against requirements and consistency with external evidence, and specific testing of two mandatory and one local indicators.

PH added that Deloitte has now seen the Head of Internal Audit Opinion to support its Opinion. He also asked if the Trust would respond to the comments made by Healthwatch Wakefield in relation to safety incidents. TB responded that the information is not readily available and the Trust will respond but not before the report is finalised.

Deloitte was satisfied with the content and consistency of the report. With regard to the testing of the three indicators, one minor discrepancy was found in relation to CPA seven-day follow up and one recommendation made in relation to the accuracy of recording the contact date. A 'B' rating was given due to the minor discrepancies.

For delayed transfers of care (DToC), the position was fairly stated with no errors in quarter 4. There is, however, scope for improvement and a recommendation made in relation to date recording in patients' notes. A 'B' rating was given.

In relation to the local indicator around pressure ulcers, there was a lack of precision around the definition and a mis-match between the data and the definition. The data and definition were clarified and re-tested with one recommendation around the timing of assessment. TB commented that this demonstrates the challenge to marry up the choice of indicator and the data the Trust has or collects in support.

He assured the Committee that none of the findings represented a patient safety issue and the Trust's response will be reported through the Clinical Governance and Clinical Safety Committee.

IB asked if there was any comparative information with other Trusts. TB responded that the Trust would usually seek comparisons through Deloitte. PH commented that the Trust tends to be very good. TB added that there have been very positive comments from partners but this could be because the Trust explains its performance better than others. IB asked Deloitte to include a comparison with other Trusts in its report to the Members' Council.

Action: Deloitte

I**t was RESOLVED to APPROVE the quality report for 2014/15.**

AC/15/45 Internal audit annual report 2014/15 (agenda item 6)

MD took the Committee through the highlights of the report. He commented on three reports yet to be presented to the Audit Committee. These do inform the Head of Internal Audit Opinion but are not formally reported to the Committee until July 2015.

It was RESOLVED to NOTE the internal audit annual report for 2014/15.

AC/15/46 Any other business (agenda item 7)

LC commented that this had been an impressive performance by the finance team and development of the quality accounts, particularly against tighter requirements and timescales.

AC/15/47 Date of next meeting (agenda item 8)

The next meeting will be held on Tuesday 7 July 2015 at 14:00 in rooms 49/50, Folly Hall, Huddersfield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 21 April 2015

Present:	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust (Chair)
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
Apologies:	Ian Black	Chair of the Trust
	Dawn Stephenson	Director of Corporate Development
In attendance:	Nette Carder	Interim BDU Director, CAMHS and forensic services (item 12)
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Jane Riley	Chief Pharmacist (item 14.1)
	Karen Taylor	BDU Director, Calderdale, Kirklees and specialist services
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)

CG/15/19 Welcome, introduction and apologies (agenda item 1)

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

CG/15/20 Minutes of the previous meeting held on 3 February 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 3 February 2015.

CG/15/21 Matters arising (agenda item 3)

There were six matters arising.

CG/14/90 Reduction and management of Child Exploitation (agenda item 3.1)

The update was noted. Mike Doyle (MD) commented that the Trust tries to share best practice and encourage others to do so but activity against the Jay Report is led by safeguarding boards. He confirmed that this applies to Barnsley as well. Julie Fox (JF) commented that the approach to training appears a little ad-hoc so how would the Trust ensure all staff are trained. MD responded that level I training is subject to a performance indicator against which the Trust will be measured and other levels are built into safeguarding arrangements. It was also suggested that links could be made with youth offending teams, particularly in relation to child and adolescent mental health services.

CG/15/07 Care Quality Commission visits to Mid-Yorkshire Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust (agenda item 3.2)

The responses to the questions raised at the last meeting were noted by the Committee. The information provided assurance that the inadequate rating given for safety at Mid-Yorkshire Hospitals NHS Trust would not impact on Trust services or staff.

CG/15/07 Outcome of 'mock' Care Quality Commission visits to rehabilitation and recovery units in Calderdale and Kirklees (agenda item 3.3)

Karen Taylor (KT) advised that, given the action in place at Enfield Down and Lyndhurst to improve leadership and management, and aspects of the service, the review is now scheduled for May 2015. An update will be brought to the next meeting.

Action: Karen Taylor

CG/15/12 Quality performance report – Committee scrutiny (agenda item 3.4)
HW explained that the production of the quality performance report is timed to coincide with Trust Board meeting dates and, therefore, would always come to the Committee after discussion and scrutiny at Trust Board. She proposed that the Committee should be asked to review in more detail any issues or concerns emerging from Trust Board. This was supported by the Committee.

CG/15/12 Cluster reviews and action agreed through the Data Quality Steering Group (agenda item 3.5)
Tim Breedon (TB) reported that the Data Quality Steering Group has overseen development of robust data quality improvement plans in each district. This work has seen improvements but some quite critical issues remain. The next meeting of the Steering Group will look at the 'top ten' issues from a performance and information and operational perspective. The meeting will take a workshop format to agree a solution for each issue. The Trust has also begun to see improvement through the practice governance activity and this will provide a focus for continued improvement. It was agreed to bring the outcome from the workshop and improvement plan to the next meeting.

Action: Tim Breedon

Adrian Berry (ABe) added that objectives for medical staff job planning will include involvement in the improvement of clinical data quality.

CG/15/13 Service users into employment (agenda item 3.6)
JF commented that how the Trust will improve in this area is missing from the paper whether the target is lowered or not. There are also other areas where the Trust can work with others to improve the level of performance and this is also not reflected in the paper. The Committee did not feel assured on receipt of the paper as the Committee viewed it as taking a compliance approach rather than one focussing on improvement. HW would like to see an articulation of where accountability and responsibility lie, more visibility and operational support, and that this is treated as a priority. It was agreed to include in the remit for the newly-established Trust Board Forum for equality and inclusion.

Action: Dawn Stephenson

CG/15/22 Annual report to the Audit Committee 2014/15 – summary of issues arising out of the self-assessment and agreement of action (agenda item 4)

A number of actions were agreed and will be reviewed by the Chair of the Committee at agenda setting for the September 2015 meeting.

Action: Chair of the Committee

CG/15/23 Quality impact assessment of cost improvement programme on Trust services (agenda item 5)

TB introduced this item and commented that the process has shown a real improvement in the quality of the challenge for each proposed cost saving. The trio arrangements now in place have improved the drive from bottom/up and the comments from Deloitte regarding the openness and transparency of the process demonstrate the benefit of having no threshold. The quality and financial 'ratings' have also been aligned to give an overarching rating for each proposed area.

There are still some areas to be reviewed where the plan is not fully formed or substitutions/mitigation are being worked up. A process has also been applied to cost pressures and this will be integrated in 2016/17.

JF asked whether the process could include scrutiny of the vacancy factor. TB responded that the purpose of the review is to ensure safety of services and management of risk. Alan Davis (AGD) added that this is an area that needs ongoing scrutiny of the position within BDUs.

CG/15/24 Review of the implementation of twelve-hour shift patterns (agenda item 6)

MD highlighted the key areas from the interim review, which it was agreed was inconclusive. Concerns expressed by staff about a negative impact on quality and safety were not borne out by the evidence from other sources monitored through the quality performance report. As a result, there will be a more detailed review of 'hard' data to assess the impact on quality and safety, such as sickness, staffing levels, etc., and a series of focus groups to better understand the basis of staff concerns, which will also link to the staff wellbeing survey. The Committee also suggested that information on the numbers and analysis by BDU would also be helpful. JF added that the paper provides a benchmark for further analysis. The Committee asked to receive a further report in six months' time (September 2015). AGD also suggested including the view of the 'trios' on the issues raised by staff. There will also be an internal communications plan for the Trust's response.

Action: Mike Doyle

CG/15/25 Sub-groups – exception reporting (agenda item 7)

Item 7.1 Drugs and therapeutics

Adrian Berry (ABe) highlighted the positive nature of the development of the Pharmacy Strategy (see item 14.1) and the relationship with BDUs, which has been turned round since the appointment of the new Chief Pharmacist. Key issues remain with primary care prescribing for secondary care, and e-prescribing and interoperability with other systems.

Item 7.2 Health and safety

AGD alerted the Committee to the compliance visit for the security management service at the end of February 2015 from which the Trust received good feedback. The Trust was assessed as green in all areas apart from publicising prosecutions, which is may be appropriate to do in the public interest, and pursuing criminal damages. The Executive Management Team (EMT) will discuss further. AGD will bring the report and action plan to the next meeting.

Action: Alan Davis

The national staff survey has shown an upward trend for take-up of health and safety training; however, this remains at the lower end of Trusts.

Item 7.3 Infection Prevention and Control, item 7.4 Safeguarding and item 7.5 Managing aggression and violence

The reports were noted.

CG/15/26 Incident management (agenda item 8)

Incident management Q3 2014/15 (agenda item 8.1)

The report was noted. Themes will be a key area for scrutiny for Trust Board and the Members' Council in the annual report and what action the Trust is taking on areas it can impact on.

CG/15/27 Care Quality Commission (agenda item 9)

Outcome of thematic review of crisis services in Barnsley (agenda item 9.1)

The Trust has received a draft report for accuracy checking. This will be circulated to the Committee when it is formally issued. TB reported that, on the whole, this was a positive report with the unavailability of the Section 136 suite being the main issue raised although the Trust did have a clear rationale for its position.

Care Quality Commission Mental Health Act visits – clinical and environmental (agenda item 9.2)

The report on clinical issues was noted. AGD updated the Committee on the position with Castle Lodge and Lyndhurst.

CG/15/28 Annual reports (agenda item 10)

Medicines management (agenda item 10.1)

The report was noted. With the appointment of a new Chief Pharmacist, the format and content for the annual report will change.

CG/15/29 BDU governance groups annual report 2014/15 (agenda item 11)

The report was noted and the conclusion that BDUs have continued to make significant progress in embedding the structures and processes by which they will continue to review and monitor governance. The report provides the basis for work to be progressed in 2015/16. The Committee was happy to receive a high level summary for next year's report. KT commented that the Trust is beginning to reap the benefits of the partnership between BDUs and support services, and the introduction of 'trios'. It was noted that the Quality Improvement Group will meet for the first time on 8 July 2015.

CG/15/30 Child and adolescent mental health services (CAMHS) (agenda 12)

TB and Nette Carder (NC) provided an update on the paper presented to Trust Board at the end of March 2015.

- Data quality emerged as a key issue from the summit with commissioners.
- Mandatory training is slowly improving. The Committee asked for future reports to state the number of employees still to go through the mandatory training as it would be more useful than percentages given the small size of the team.
- The 15-steps challenge will be used as a framework for visits to services by commissioners.
- A compliance report for CAMHS is to be developed.
- The next summit will take place on 8 May 2015.
- No decision has yet been made on the additional investment although it is expected by the end of April 2015.
- EMT has agreed to start the recruitment process for crisis/intensive home-based treatment staff at its own risk.
- HW and JF will visit the service on 12 May 2015.

JF asked what the Trust is doing about the non-achievement of targets in Barnsley. NC responded that there is much work to do and data quality issues will be addressed. Although the current focus is on Calderdale and Kirklees, the Trust is aware of the need to provide some focus on Barnsley.

AGD commented that mandatory training in some areas is a higher priority, such as safeguarding and information governance, and suggested this is where the focus should be to achieve 100% of staff trained not the Trust target of 80%.

CG/15/31 Horizon review (agenda 13)

KT updated the Committee and a further report will be made to the June 2015 meeting.

Action: Karen Taylor/Tim Breedon

CG/15/32 Strategies (agenda 14)

Pharmacy Strategy (agenda item 14.1)

The Committee received a presentation from Jane Riley, Chief Pharmacist.

A future piece of work is to review and scope the current arrangements across the Trust to assess the benefits and practicalities of operating through service level agreements or providing the service in-house.

Measures of success for the revised strategy will include improved medicines management, mitigating the increase in drugs spend and improving the motivation and morale within the team. There will also be a link with the Trust's transformation programme through transparency for current provision and ensuring the service provides what BDUs want.

HW asked the Chief Pharmacist to return to the Committee with her vision for the service, how it will be achieved and how it will be measured in a simple and concise format.

Action: Adrian Berry

Patient Safety Strategy (agenda item 14.2)

The paper was reviewed and supported by the Committee with positive comments on the approach described. The Strategy will be presented to Trust Board for approval on 28 April 2015.

CG/15/33 Quality Accounts 2014/15 (agenda item 15)

The report was noted and the format supported. A first draft of the quality priorities for 2015/16 was tabled. The Committee was asked to provide any comments to TB by 24 April 2015.

TB agreed to check performance against the ethnicity coding target against the data provided to the Mental Health Act Committee.

Action: Tim Breedon

CG/15/34 Unannounced/planned visits annual report (agenda item 16)

JF suggested that the view of twelve-hour shifts from a staff perspective is included in the areas reviewed in 2015/16.

Action: Tim Breedon

CG/15/35 Date of next meeting (agenda item 17)

The next meeting will be held on Tuesday 16 June 2015 at 14:00 in the boardroom, Kendray, Barnsley. There will be a meeting of the Committee to approve the Quality Accounts for 2014/15 on Tuesday 12 May 2015 in room 52, Folly Hall, Huddersfield.

The Chair ended by commenting on the extent of the papers presented to this meeting and it was suggested that the Committee should receive a summary and highlights with a clear indication of what the Committee is being asked to do or to comment on where reports are lengthy.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 12 May 2015

Present:	Ian Black	Chair of the Trust
	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust (Chair)
	Adrian Berry	Medical Director
	Alan Davis	Director of Human Resources and Workforce Development
	Dawn Stephenson	Director of Corporate Development
Apologies:	Tim Breedon	Director of Nursing, Clinical Governance and Safety
In attendance:	Karen Batty	Assistant Director, Nursing, Clinical Governance and Safety
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Charlotte Dyson	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)

CG/15/36 Welcome, introduction and apologies (agenda item 1)

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

CG/15/37 Consideration and approval of Quality Accounts 2014/15 (agenda item 2)

Adrian Berry (ABe) introduced this item on behalf of Tim Breedon. He commented that members of the Committee will be aware of the process to develop the Quality Accounts. The report very much demonstrates that this is work-in-progress and the focus is on improvement, providing a snapshot of achievement against a set of objectives and targets.

Ian Black (IB) asked whether it would be useful to include a page setting out the Trust's achievements, particularly in terms of national awards or include under the appropriate priorities. HW suggested including within the Chair and Chief Executive's introduction.

Action: Karen Batty

Jonathan Jones (JJ) asked what will happen to the Quality Accounts following this meeting. It was explained that they would be amended to reflect comments from the Committee and presented to the Audit Committee for formal approval with the annual report and accounts on 22 May 2015 following which they will be sent to Monitor. The document will also be uploaded onto NHS Choices and the Trust's websites after laying before Parliament as part of the annual report and accounts.

Karen Batty (KB) provided feedback from the Members' Council Quality Group on 6 May 2015. The feedback was very positive and the report seen as an easier read with good signposting. Child and adolescent mental health services (CAMHS) were raised as an issue, particularly following the local press coverage. Wakefield HealthWatch also raised CAMHS in Wakefield as an issue. It was agreed it was important to include reference to CAMHS (under the CAMHS section) with a clear indication of what the Trust is commissioned to provide.

Action: Karen Batty

Julie Fox joined the meeting.

In relation to clinical record keeping/recording clinical data, the report needs to be clear where the Trust has challenges and issues currently and where these lie within the organisation. It was agreed to include an explanation of the challenges, risks and impact under Priority 4.

Action: Karen Batty

KB went on to update the Committee on the position with the audit of the Quality Accounts. Three mandatory indicators were identified for mental health, of which the Trust has to choose two (*in italics*):

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

The Trust is also required to identify one local indicator, which was identified as pressure ulcers by the Members' Council.

Deloitte tested quarters 1 to 3 followed by quarter 4 in April 2015. Very minor issues were found in the seven-day follow up indicator.

In relation to delayed transfers of care (DToC), for quarters 1 and 3, in 50% of records, multi-disciplinary team agreement was missing (representing fourteen out of 25 records). As a result, all 142 DToC were audited in detail. In 56%, evidence was found. From the remaining 44%, Deloitte assumed that the delay started six days from Performance and Information receiving the DToC form from the service and the re-calculated figures were reported to Monitor. There was a minimal 0.4% difference, which keept the Trust within the Monitor target. In the quarter 4 review, no errors were found given the work undertaken within BDUs.

For the local indicator in relation to pressure ulcers, all patients should receive a Waterlow assessment by the second contact. There are a number of issues in defining the population group, which will be discussed with Deloitte and Performance and Information.

The Committee went on to look at each part in detail.

Part 1
The addition of key achievements was requested earlier in the meeting and a number of detailed amendments were suggested.

Part 2
A number of detailed amendments were suggested.

Part 3
A number of minor amendments were suggested for the dashboard and detailed narrative on each priority.

The following general comments were made.

- KB was asked to include more ethnic diversity in the photos used.
- Some acronyms were missing from the glossary.
- Acronyms should be included in full on first presentation.
- It was agreed to include reference to the Trust having no 'never events' in 2014/15.
- It was agreed to circulate the stakeholder responses to the Committee.

Action: Karen Batty

It was RESOLVED to APPROVE the final draft of the Quality Accounts for 2014/15 and to recommend their approval to the Audit Committee as part of the annual report and accounts for 2014/15.

CG/15/38 Date of next meeting (agenda item 3)

The next meeting will be held on Tuesday 16 June 2015 at 14:00 in the boardroom, Kendray, Barnsley.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 12 May 2015

Present:	Julie Fox	Non-Executive Director (Chair)
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Non-Executive Director
	Adrian Berry	Medical Director
	Dawn Stephenson	Director of Corporate Development
Apologies:	**Members**	
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Attendees	
	Alwyn Davies	Lead Professional, Safeguarding Adults, Barnsley Hospital NHS Foundation Trust – acute trust representative
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Antonis Lakidis	Associate Specialist, Calderdale
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Ian Black	Chair of the Trust
	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Charlotte Dyson	Non-Executive Director
	Yvonne French	Assistant Director, Legal Services
	Lorraine Jeffrey	Independent Associate Hospital Manager
	John Newsome	Practice Governance Coach, Kirklees (item 2.1)
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative

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

Julie Fox (JF) welcomed everyone to the meeting. The apologies, as above, were noted. It was noted that Geoff Naylor has resigned as an Associate Hospital Manager. JF will write to Geoff to thank him for his contribution to and support for the Mental Health Act Committee and Hospital Managers' Forum.

Action: Julie Fox

MHAC/15/16 The Act in practice (agenda item 2)

Access to services – crisis teams, psychiatric liaison, four-step model for mental health (agenda item 2.1)

The Committee received a presentation from John Newsome, Practice Governance Coach, acute/in-patient services, Kirklees, on the four-step model for mental health and its impact on crisis and acute services.

MHAC/15/17 Legal update/horizon scanning (agenda item 3)

Mental Health Act Code of Practice briefing note (agenda item 3.1)

The Committee noted that an action plan has been developed for policies and procedures that will be affected by the revised Code of Practice with a view to amendment and approval by the end of August 2015.

Bostridge vs. Oxleas NHS Foundation Trust (2015) – Court of Appeal – Deprivation of Liberty (Mental Capacity Act) (agenda item 3.2)

The Committee noted the summary report.

"More warnings on Deprivation of Liberty" (agenda item 3.3)

Local authority representatives reported ongoing issues with a backlog of cases for Deprivation of Liberty Safeguards (DoLS), exacerbated by scheduled reviews of DoLS. Julie Carr (JC) commented that the issue for the Trust is to ensure patients on wards who lack capacity and are deprived of their liberty are detained legally, which will be addressed through ongoing training for Trust staff. Local authority representatives were asked to liaise with Yvonne French (YF) regarding their particular areas of concern.

Action: Local authority representatives

Informed Consent to Treatment – the new duty to warn (agenda item 3.4)

The Committee noted the report. Adrian Berry (ABe) commented that this did not change how the Trust obtains informed consent from patients but awareness will be raised within the Trust. ABe and Tim Breedon (TB) were asked to provide feedback at the next meeting.

Action: Adrian Berry/Tim Breedon

General Election guidance notes (agenda item 3.5)

The action taken by the Trust was noted by the Committee. Ian Black (IB) asked for an indication of the turnout.

Action: Yvonne French/Julie Carr

JF commented that she was keen to see the Trust encourage eligible patients to vote and that this is replicated for local elections as well as national. She asked for feedback at this time next year in relation to local elections.

Action: Yvonne French

MHAC/15/18 Minutes from the previous meeting held on 24 February 2015 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 24 February 2015.

MHAC/15/19 Matters arising from previous meeting (agenda item 5)

There were two matters arising.

MHAC/14/43 Bretton Centre

ABe reported on the positive work undertaken, particularly in terms of engaging staff and facilitating culture change. This has been evidenced by an improvement in the outcome of the staff wellbeing survey.

MHAC/15/08 Harmonisation of policies

It was noted that this will be included in the review of policies and procedures in response to the revised Mental Health Act Code of Practice.

MHAC/15/20 Compliance and assurance (agenda item 6)

Mental Health Act Committee annual report to Trust Board – feedback from Audit Committee and Trust Board (agenda item 6.1) and Self-assessment (agenda item 6.2)

JF confirmed that the Committee's annual report was presented to the Audit Committee on 7 April 2015 and the Committee was assessed as compliant. The report included the Committee's self-assessment and three areas in particular were highlighted:

- training for new members;
- an overview of the Mental Health Act and its Sections would be helpful (it was agreed to circulate with the papers for the next meeting); and

Action: Yvonne French

- strengthen links with the Audit Committee (the two Chairs have agreed to foster closer links).

Training summary – Non-Executive Directors/Hospital Managers (agenda item 6.3)

YF took the Committee through the training summary.

MHAC/15/21 Compliance and assurance – Transformation update (agenda item 7)

This item was not taken.

MHAC/15/22 Compliance and assurance – Audit and compliance reports (agenda item 8)

Consent to Treatment (agenda item 8.1)

JC outlined five recommendations as a result of the audit:

- to continue to work with RiO for paperlight Mental Health Act files;
- to remind Responsible Clinicians of the need to record the discussion and assessment of capacity in patients' clinical records;
- to review the Mental Health Act internet page and information regarding Consent to Treatment in the light of the new Code of Practice;
- to retain Consent to Treatment on the Committee's annual audit work plan; and
- to establish a revised Mental Health Act training programme in response to the revised Code of Practice.

ABe commented that he was disappointed with the result of the audit, particularly in relation to the T2 part of the audit as discussion took place in relation to requirements, which were communicated very clearly to consultants. He will ensure that an individual approach is now initiated to ensure compliance.

Action: Adrian Berry

IB commented that he would expect to see an opinion as a result of an audit (in the same way that internal and external audit provide the Trust with an opinion). He also asked when the re-audit would take place and he would expect this to include an opinion. The Committee also asked to see the outcome extrapolated to give an assessment for the Trust as a whole.

Action: Julie Carr

The Committee also asked ABe to agree a timescale for the re-audit with TB; however, there was general agreement that this should be in six months.

Action: Adrian Berry/Tim Breedon

JF commented that the concern for Non-Executive Directors is that each Mental Health Act audit shows poor performance on recording and meeting the rights of service users. Helen Wollaston (HW) suggested asking the Data Quality Steering Group to review Mental Health Act record keeping as part of its remit. ABe and TB were asked to bring back an update on action taken in the interim to the next meeting and the Committee would like to have sight of the terms of reference for the re-audit in six months.

Action: Adrian Berry/Tim Breedon

MHAC/15/23 Compliance and assurance – Care Quality Commission Visits (agenda item 9)

Recent visits (agenda item 9.1)

The five monitoring visits to Gaskell ward, Fieldhead (6 November 2014), Priestley ward, Newton Lodge, Fieldhead (6 November 2014), Ward 18, Priestley Unit, Dewsbury (27 November 2104), Lyndhurst, Elland, Calderdale (7 January 2015) and Trinity 1, Fieldhead (10 March 2015) were noted.

Outstanding actions/progress report (agenda item 9.2)

Environmental issues

IB expressed a concern at the length of time it takes to action improvements under the minor capital programme. JF reminded the Committee that it had agreed at the last meeting that actions should be completed within three months or have a strong rationale for any delay. The Committee agreed it would also like to see the Estates TAG prioritise any issues arising from CQC visits and to see a Trust-wide policy developed to provide a consistent approach to the risk assessment of windows/doors and observation panels. On behalf of the Committee, JF invited Alan Davis (AGD) as lead Director to come to the next meeting for this item to explain the Trust's position, action taken and when issues will be resolved. The Committee also asked for a detailed update on the outstanding issues in relation to Ashdale, Castle Lodge and Lyndhurst from AGD.

Action: to be raised with Alan Davis

Clinical issues

JF asked for further information on areas where audits have been undertaken in terms of the outcome and the action taken as a result. She also asked for the date the CQC report is received to be included as this has an impact on some of the timescales identified by services to resolve issues.

Action: Yvonne French

MHAC/15/24 Monitoring Information (agenda item 10)

Monitoring information Trust-wide January to March 2015 (agenda item 10.1)

The Committee asked for an analysis of 'death of patients subject to the Mental Health Act'.

Action: Yvonne French

Local authority information (agenda item 10.2)

In Barnsley, the issue remains with recording for Section 136. In Wakefield, figures for referral to the Section 136 suite are higher in comparison with other areas. The data is useful as it provides information to support any bid for additional funding for Section 136 provision. The Committee agreed it would be useful to receive information on the use of Section 136 suites by district.

Action: Tim Breedon

The issues around filling of Approved Mental Health Professionals posts in Calderdale were noted.

Hospital Managers' Forum March 2015 (agenda item 10.3)
The Forum notes from March 2015 were received and noted. The uplift for Hospital Managers' payment of 1% from 1 April 2015 was noted.

Compliments/complaints/concerns in relation to the Mental Health Act January to March 2015 (agenda item 10.4)
The report was noted. It was suggested that the Committee should invite someone from customer services to offer a general overview of the process and how the Trust learns from complaints, etc.

Action: Dawn Stephenson

MHAC/15/25 Partner agency update (agenda item 11)

Local authority (agenda item 11.1)
No further items were raised.

Acute health care (agenda item 11.2)
No items were raised.

MHAC/15/26 Key messages for Trust Board (agenda item 12)

The key issues to report to Trust Board were agreed as:

- Consent to Treatment audit; and
- new Mental Health Act Code of Practice.

MHAC/15/27 Any other business

On behalf of the Committee, JF thanked HW for her contribution to and support for the Committee, particularly during her time as Chair.

MHAC/15/28 Date of next meeting (agenda item 13)

The next meeting will be held on Tuesday 4 August 2015 from 14:00 to 16:30 in training room 3, Learning and Development Centre, Fieldhead, Wakefield.

Minutes of the Remuneration and Terms of Service Committee held on 21 April 2015

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

RTSC/15/18 Welcome, introduction and apologies (agenda item 1)

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

RTSC/15/19 Minutes of the meeting held on 10 February 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes from the previous meeting held on 10 February 2015.

RTSC/15/20 Matters arising from the meeting on 10 February 2015

RTSC/15/10 Directors' contracts of employment

IB commented that he would like to discuss further with Non-Executive Director colleagues the move to extend the notice period for the Chief Executive at the next meeting. This was extended for all Executive Directors from three to six months at the last meeting. He asked Alan Davis (AGD) to obtain benchmarking information from other Trusts for Non-Executive Directors to consider.

Action: Alan Davis

RTSC/15/21 Human resources exception report (agenda item 3)

Sickness absence

AGD informed the Committee that the year-to-date sickness absence rate is 4.8%. There are two areas of concern.

1. Medium secure services are beginning to show an improvement but the sickness absence rate in low secure services is increasing. This reflects a number of underlying cultural issues, which will be addressed as part of the action plan resulting from the staff wellbeing survey and action already in train through a partnership between HR and the Deputy Director. The action plan from the staff wellbeing survey will be developed during May 2015 in conjunction with the Deputy Director. Key to successful delivery will be to challenge the mind-set that forensic services is 'different'.
2. The sickness absence rate in child and adolescent mental health services in Calderdale and Kirklees reflects wider issues within the service. A slight improvement can been seen, which has been reported to Trust Board. It was noted that the second CAMHS summit will be held on 8 May 2015.

The final figure for 2014/15 will be available at the end of April 2015. AGD will bring a proposal for a realistic but stretching target for 2015/16 with benchmarking information to the next meeting.

Action: Alan Davis

The Chief Executive (SM) commented that having the 4% target has supported a reduction in the absence rate; however, the operational and management action taken in risk areas needs to be understood. Risk areas must continue to be targeted, supported by a strong improvement plan and disciplined performance management system at operational level and it may be that the Trust needs to introduce operational targets. AGD added that the Committee should not lose sight of the performance and improvement in some areas.

Suspensions

The Committee was concerned that timescales are beginning to drift. AGD explained that this was mainly due to delays in instigating, and the capacity of operational managers to undertake, investigations. There have been a number of appointments to the bank with staff who can cover investigations. He added that four weeks is the norm and eight weeks the exception unless there is a police investigation.

National NHS staff survey

AGD tabled a paper with a high level summary of the findings. The Committee noted the small number of staff who completed the survey (390 from 800). The staff wellbeing survey has over 2,000 respondents; however, the national survey is used to inform various national indicators. Three areas were highlighted.

1. There has been a focus on the re-design of processes for mandatory training to improve access for staff.
2. Action is in place, through the Director of Nursing and Practice Governance Coaches, to review the outcome on staff errors and near misses.
3. Staff communications and engagement. SM commented that he was disappointed at the this outcome, which reflects his concern in this area, particularly over the last eighteen months, and reflects discussion at Board level on the introduction of a director-level focus to develop a commercial and marketing/branding approach.

SM went on to update the Committee on the recruitment of a Commercial Director (see agenda item 5.)

RTSC/15/22 Leadership and management development strategy update (agenda item 4)

There will be an update for Trust Board at its meeting in April 2015 and this will also form part of the Trust Board discussion at the strategy meeting in May 2015. AGD updated the Committee on current leadership and management development activity and progress on strategic developments, including talent management. AGD was asked to update the Committee on 'high performers', including the numbers and diversity of the pool. Helen Wollaston (HW) asked that this paper also covers consultants in terms of appointments and succession planning, a gap analysis across the organisation and action the Trust could take.

Action: Alan Davis

RTSC/15/23 Director structures (agenda item 5)

Commercial Director

IB and SM met with Chris Davies of Harvey Nash regarding the Commercial Director appointment and they will support the Trust in a recruitment process. SM will circulate the specification provided to Harvey Nash.

Action: Steven Michael

Kate Henry, Head of Communications at NHS Improving Quality, will join the Trust on secondment at the end of May 2015 to the end of December 2015 reporting directly to SM.

This will mean that some functions currently within the Director of Corporate Development portfolio will move across to the Commercial Director. The secondment will also enable SM to look at the overarching arrangements for business planning and development.

It was suggested that Kate Henry and James Drury are invited to September's Trust Board to present on the Trust's commercial and marketing approach.

Action: Bernie Cherriman-Sykes to note for agenda setting

Operations
SM updated the Committee on developments in this area.

RTSC/15/24 Directors' contracts of employment (agenda item 6)

Directors' contracts in relation to redundancy currently reflect Agenda for Change arrangements. The paper sets out the changes in light of national changes. **It was RESOLVED to APPROVE option 2** (mirror new Agenda for Change redundancy arrangements with a locally determined salary cap based on the same principles of 80% of the highest salary (that it, the Chief Executive), which would be between £120,000 and £136,000 if the minimum or current salary was used) **in order for Directors' contracts to be finalised.**

However, although the Committee is approving this option, IB commented that it will need to consider the Chief Executive's position separately as the Chief Executive's pay is the benchmark for other Directors. He would like to know what other Trusts are introducing or considering. AGD was asked to bring information to the next meeting in relation to the Chief Executive role only.

Action: Alan Davis

RTSC/15/25 Well-led review (agenda item 7)

SM informed the Committee that an EMT time out was planned for 7 May 2015, which will review the feedback from the Board's assessment of its position. The Board structure will be an important part of the review and to that end he commented that, by discharging his accountability in some areas through this Committee, he has found the Committee enormously helpful in supporting the difficult discussions and decisions Trust Board has to make and provides challenge for the Chief Executive in his thinking, particularly around structures.

RTSC/15/26 Clinical Excellence Awards

AGD informed the Committee that he and the Medical Director met with the British Medical Association (BMA). The BMA was informed that the Trust would not progress the national scheme and it wished to reward clinical excellence linked to the strategic goals of the Trust and contribution to its leadership and management. With the Medical Director, he will develop a paper to share with the BMA and will bring back a detailed proposal to the Committee at the next meeting.

Action: Alan Davis

RTSC/15/27 Directors' performance related pay scheme (agenda item 9)

SM commented that his quarter 3 reviews with Directors were complete and he has asked Directors to prepare for quarter 4 reviews during May, which will include a review of the 360° appraisals earlier in the year. The gateway and corporate requirements have been broadly met. He will review individual Director objectives during the quarter 4 reviews.

The Committee agreed to arrange an additional meeting towards the end of May 2015 to receive the outcome of the Chief Executive's reviews with Directors and his proposals in relation to performance related pay.

Action: Steven Michael/Bernie Cherriman-Sykes (for meeting date)

IB commented that Non-Executive Director appraisals would be undertaken to the same timescales and the Committee structure will be a key focus for the end-of-year reviews.

RTSC/15/28 Any other business (agenda item 10)

No other business was raised.

RTSC/15/29 Date of next meeting

The next meeting will be held on Tuesday 14 July 2015 at 14:00 in the Chair's office, Block 7, Fieldhead, Wakefield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 6

Title:	**Annual report, accounts and Quality Report 2014/15**
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 2014/15.
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 2014/15 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 2015.
Executive summary:	Background The Audit Committee has delegated authority from Trust Board to review, scrutinise and approve the annual report, accounts and Quality Report. The Committee reviewed and approved the documents for 2014/15 at its meeting on 22 May 2015. The report and accounts with supporting documents were submitted to Monitor in line with the national timetable and have been submitted to the Department of Health for laying before Parliament. Annual report 2014/15 The annual report was developed in line with Monitor's requirements and this was confirmed by the Trust's external auditors. The Committee approved the report. Annual accounts 2014/15 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 continuity of services risk rating of 4. The Trust received an unqualified audit opinion on the 2014/15 accounts and a positive opinion on the requirement to demonstrate Value for Money. The Head of Internal Audit Opinion for 2014/15 provided significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Committee approved the accounts for 2014/15. Quality Report 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 2015. The external assurance review conducted by Deloitte was received by the Audit Committee on 22 May 2015 (included in these papers for Trust Board). Deloitte was satisfied with the content and consistency of the report. Deloitte also undertook a data quality review of two nationally mandated indicators (delayed transfers of care and CPA seven-day follow up). One minor discrepancy was found in relation to CPA seven-day follow up and one recommendation made in relation to the accuracy of recording the contact date. A 'B' rating was given due to the minor discrepancies. For delayed transfers of care (DToC), the position was fairly stated with no errors in quarter 4. It was considered, however, that there is scope for improvement and a recommendation made in relation to date recording in patients' notes. A 'B' rating was given. A limited assurance opinion was issued by Deloitte. Deloitte also undertook a review of the local indicator chosen by the Members' Council for pressure ulcers and Waterlow assessments. Deloitte found a lack of precision around the definition and a mis-match between the data and the definition. The data and definition were clarified and re-tested with one recommendation around the timing of assessment. The Committee approved the Quality Report for 2014/15. <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 2015. As required, the Trust's annual report, accounts and Quality Report were sent to the Department of Health for laying before Parliament and this was done on 10 June 2015. The documents have subsequently been submitted to Monitor and included on the Trust's website.
Recommendation:	**Trust Board is ASKED to RECEIVE and ADOPT the annual report, accounts and Quality Report for 2014/15.**
Private session:	Not applicable.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2014
Director of Finance report to Audit Committee (22 May 2015)

Annual Accounts Financial Year 2014/15

1.0 Introduction

The Audit Committee has been requested by the Trust Board to scrutinise the Trust's Annual Accounts for the financial year ended 31 March 2015, and to subsequently decide whether to recommend the Trust Board adopt these accounts. The Trust is required to submit its financial position for the period 1 April 2014 to 31 March 2015 to Monitor in the required format.

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

The audited accounts, including details of senior managers' remuneration, are presented to this Committee. These accounts are made available to the public as part of the Trust's Annual Report and includes details of the Trust's quality report.

The content of the Annual Report has been reviewed by the Trust's external auditor to ensure it meets disclosure requirements. Trust Board agreed the processes and content of the Annual Report and the Quality Report/Accounts. In addition, the Members' Council has a Quality Group, which is a sub-group of the main Members' Council, and this Group has been actively involved in the compilation of the Quality Report for 2014/15.

2.0 Trust Financial Performance 2014/15 overall

The Trust's planned annual surplus for 2014/15 was £2.58 million; actual surplus was £3.11 million and, overall, was £0.53 million better than planned. Capital expenditure for the year was £6.13 million against an original plan of £11.78 million largely due to delays experienced in existing projects and review of the overall Trust's Estates Strategy.

As at the end of March 2015, Monitor's financial risk rating (Continuity of Service Risk Rating (COSRR)) 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 2014/15. 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 92% of invoices within 30 days. In addition, the Government has requested all public sector bodies to pay local small and medium sized suppliers within ten workings days. In response to this, the Trust paid 69% of local suppliers within ten days during 2014/15 to help sustain local communities. Work remains ongoing to maintain and improve these payment rates.

The Trust delivered the 2014/15 cost improvement programme in full, identifying £12.9 million. This included £10.1 million in line with the original plan (78%) with £2.8 million found through mitigations and substitutions. Of the £2.8million, £1.1 million (8%) was identified recurrently and £1.7 million (14%) non-recurrently.

3.0 Background

Foundation Trusts are required 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 and to the Members' Council. They are commercial in style and include notes on accounting policies. The accounts presented here are the final version and include agreed audit adjustments.

3.2 Summarisation Schedules (FTCs)

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

3.3 Submission Deadlines and Adjustments

For 2014/15, the draft accounts were required to be submitted to Monitor and made available to Audit by noon on 23 April 2015. The accounts were submitted on time. The audited accounts should be received by Monitor no later than 29 May 2015 (uploaded and posted).

The audit commenced on 27 April 2015.

3.4 The Annual Governance Report

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 key strategic risks outlined in the organisational risk register include meeting the future data quality requirements and optimising the capture of clinical information on clinical systems; ensuring that the implementation of the mental health currency delivers improvement in service quality and outcomes; adverse impact of integrated services following the continued reduction in local authority funding and changes to the benefits system; ensuring momentum and implementation of transformational change within services whilst meeting challenging efficiency requirements; meeting the significant challenge of redesign and quality improvement in child and adolescent mental health services, particularly in Calderdale and Kirklees; achieving service and financial sustainability in the face of changes to national specialist services funding and ongoing national pressures on acute beds.

3.5 Accounting Policies

For 2014/15 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 January 2015 before adoption. There was no requirement for any prior period adjustments.

3.6 Major Judgement Areas

Trust Board has approved a challenging cost saving programme for 2015/16 and beyond. As a result, a number of posts are at risk and will result in a number of redundancies. This affects approximately 63 whole time equivalent (wte) posts during 2015/16 and 51 wte further redundancies during 2016/17. The Trust has estimated the associated redundancy costs and made provision for them in the 2014/15 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 £237.7million (£234.4 million for 2013/14). This is split into income from healthcare activities and other operating income.

For 2014/15 the income from healthcare activities remained relatively static, increasing by £1.1 million. Income reduced from the previous year primarily due to tariff deflation applied through contract negotiations (as experienced nationally). Income increases from new income received in-year included non-recurrent System Resilience funding from Local Commissioning Groups.

Other operating income was £16.5 million in 2014/15 (£15.4 million 2013/14). This increased income arises from increased participation in the Trust lease car scheme and therefore higher contributions. This also includes additional funding for hosted budgets such as Altogether Better and specific projects.

4.1.2 Expenditure

Total operating expenditure increased by £1.5 million (0.6%) to £231.9 million (£230.4 million in 2013/14). 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 reduced by £2.6 million (1.5%). This increase is primarily due to national cost pressures including staff pay awards and incremental payments;
- overall the average wte employed by the Trust has increased during 2014/15;
- non-pay costs have remained broadly static, increasing by £0.3 million (0.5%) from 2013/14. The presentation under note 6.1 (Operating Expenditure), in conjunction with the Trust Analytical review of spend, highlights key increases in expenditure against the premises heading, which includes increased rental and rates costs alongside significant additional investment in information management and technology. There has also been additional expenditure on consultancy costs with the two largest areas being work on the Trust Transformation Programme and project specific work within Altogether Better. These have been offset by reductions in non-pay expenditure in most areas/categories.

4.1.3 Operating Surplus

The Trust's 2014/15 operating surplus before dividends and interest is £5.8 million; the surplus in 2013/14 was £5.2 million and is, therefore, an increase of £0.6 million.

4.1.4 Interest

Interest received on bank deposits during the year was £95,000 (£88,000 2013/14). No interest payments were made during the year.

This is in line with the Trust 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 to the Trust.

4.1.5 Public Dividend Capital (PDC)

Public dividend capital dividend payable during the year amounted to £2.8 million (£1.5 million 2013/14). The main reason for this increase is the PDC due for the Barnsley estate transferred to the Trust on 1 April 2013. No PDC was payable against this in 2013/14 in line with national policy.

4.1.6 Retained Surplus

The Trust's retained surplus after interest, taxation, depreciation and amortisation for 2014/15 was £3.1 million (£3.8 million 2013/14). 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 £2.9 million from 2013/14 (2.7%). This totals £106.6 million. This is representative of the Trust Capital programme in year less depreciation of existing estate.

Intangible Assets

Intangible assets have reduced by £221,000 in year and the assets have been depreciated.

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 £6.1 million was included as additions to capital assets during 2014/15. The main schemes included:

- completion of the Fieldhead infrastructure scheme;
- commencement of the Calderdale and Barnsley hubs;
- preparatory work for the Wakefield hub and Fieldhead site development.

Total depreciation for the year was £5.2 million.

Investment Property

The value of Trust Investment Property in year is £0.34 million, a reduction of £0.07 million following the in-year disposal of a Trust Asset.

4.2.2 Stock

Over the twelve-month period there has been a £78,000 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 £1.2million. Further detail is provided in note 20 of the accounts. The main factor in this increase was a number of debts with other NHS providers, the largest of which have been resolved and paid post year-end.

4.2.4 Cash

Cash at bank and in hand was £32.6 million as at 31 March 2015 (£33.1 million at 31 March 2014).

4.2.5 Trade and Other Payables (Creditors)

Trade and other payables have reduced by £2.6 million overall on last year. Further detail is provided in note 22 of the accounts. The main reason is due to a reduction in NHS payables with the value in the accounts for 2013/14 being higher than normal. This was primarily around charges for Trust Estate from NHS Property Services.

4.2.6 Provisions (Current and Non-Current)

There has been an overall increase of £0.9milliuon in provisions over the period. This mostly relates to the provision for future redundancy costs. The total provision at 31 March 2015 is £8.1 million (£7.2 million 31 March 2014). The remaining provisions relate to pensions and other legal claims liabilities as detailed in note 24 of the accounts.

4.2.7 Other liabilities (Current and Non-Current)

These relate to deferred income which has reduced to £0.75million in 2014/15 (£0.84 million in 2013/14). 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 significant movements in-year relate to the retained surplus for the accounting period and the impact of the revaluation exercise.

4.3 Statement of Cash Flow

The Trust has £32.6 million of cash as at 31 March 2015 (£33.1 million at 31 March 2014); this is a reduction of £0.5 million (1.5%). The main reason for this reduction is due to the increase in PDC payments made in year.

The interest received in the period was £95,000.

Cash outflows included capital expenditure £8.2 million and £2.8 million for dividend payments. It also included the movement in debtors and the increase 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 37.

Directors' Performance Related Pay is yet to be finalised for 2014/15. The disclosure reflects the payment received during 2014/15 which is the values awarded for 2013/14.

Overall the Remuneration ratio has reduced from 7.0 to 6.4.

Alex Farrell
Deputy Chief Executive/Director of Finance

Trust Board: 30 June 2015
Agenda item 7

Title:	**Strategic Human Resources Framework (incorporating Staff Engagement and Leadership and Management Development Strategies)**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The development and engagement of the workforce is crucial for the Trust to deliver safe, effective, responsive, caring and well led services. The Strategic Human Resource Framework is designed to ensure the Trust has the right people at the right time who are resilient, engaged and capable to deliver high quality sustainable services within agreed resources.
Mission/values:	The Strategic Human Resources Framework uses the Trust's values to develop a model of Value Based Human Resource Management.
Any background papers/ previously considered by:	The Strategic Human Resources Framework incorporates the Trust's Staff Engagement Strategy and Leadership and Management Strategy which was considered at the Trust Board development session in May 2015.
Executive summary:	The NHS is facing major challenges around available resources and quality and there is recognition that this requires services to transform. The Trust's service transformation programme will require the development of new roles and skills in the workforce, effective leaders and managers and resilient and engaged staff. The Strategic Human Resources Framework is designed to ensure the Trust has an integrated approach to Workforce Development, Leadership and Management Development and Staff Wellbeing and Engagement linked to service and financial plans. Through the integration of these three strategic workforce initiatives, the Trust will be able to achieve greater organisational resilience, effectiveness and transformation with the aims of: • ensuring the Trust has the right people at the right time in the right place; • improving service quality; and • improving organisational performance. At the heart of this strategic approach to the development of the workforce are the Trust's mission and values and the thread running through the framework and supporting strategies is values-based human resource management. This has led to embedding values into the core human resource processes of recruitment, induction and appraisal. The attached paper summaries the Trust's Human Resource Strategy through a set of key strategic workforce objectives. The Strategic Human Resource Framework is designed through a matrix approach to set out a strategy on a page. The strategic objectives provide a progressive and forward looking agenda to ensure the Trust has a workforce fit and capable to deliver high quality sustainable services within a dynamic environment. In support of the framework are two key strategies:

	- Staff Engagement; and - Leadership and Management Development. There is strong evidence across all sectors that an engaged workforce improves organisational performance and productivity. The Staff Engagement Strategy develops a model for a systematic approach to supporting the whole workforce to deliver the mission and values of the Trust. The strategy recognises that, whilst everyone has responsibility for staff engagement, there four essential elements for it to be effective: • visibility of senior leaders; • engaging leaders and managers; • everyone in the Trust feeling they have a voice and will be listened to; and • living and modelling the Trust's values. The second strategy is designed to ensure the Trust has the leaders and managers to deliver safe, effective, responsive and caring services within a challenging and complex environment. The Leadership and Management Development Strategy provides a framework to support investment in the current and future leaders and managers who are essential to deliver the Trust's service and financial plans. The Strategy aims to develop a set of leadership behaviours and competencies as part of a values-based leadership and management approach. The overall aim of the Leadership and Management Strategy is to ensure the Trust can attract, retain, and develop leaders and managers through: • developing competencies based on a system leadership model, which aligns to Micro, Meso, Macro and Meta organisational levels; • developing leadership behaviours through a process of engagement; • 360 degree appraisal; • coaching and mentoring; • optimising the talent in the workforce; • supporting and developing the leaders and managers for the future. Finally, the Leadership and Management Development Strategy sets out a three-year plan for investment and development.
Recommendation:	**Trust Board is asked to APPROVE the Strategic Human Resources Framework, Staff Engagement Strategy and Leadership and Management Strategy**
Private session:	Not applicable

Trust Board: 30 June 2015

Strategic Human Resources Framework

1. Introduction

The Trust, along with all parts of the NHS, is facing unprecedented challenges with ever growing expectations of higher quality and responsiveness from the Regulators and the populations we serve running alongside the requirement to deliver significant cost savings. To meet these challenges major service transformation is needed. The Trust spends nearly 70% of its income on staff, therefore service transformation will also require a fundamental transformation of the workforce.

This paper sets out a Strategic Human Resource Framework to support the transformation of the workforce to enable safe, effective, caring, responsive and well led services to be delivered and sustained. The Strategic Human Resources framework in Appendix 1 is designed very simply to summarise the key elements of the workforce strategy on a page. Appendix 2 and 3 are two key supporting workforce strategies: Staff Engagement; Leadership and Management Development.

2. Strategic Human Resources Framework

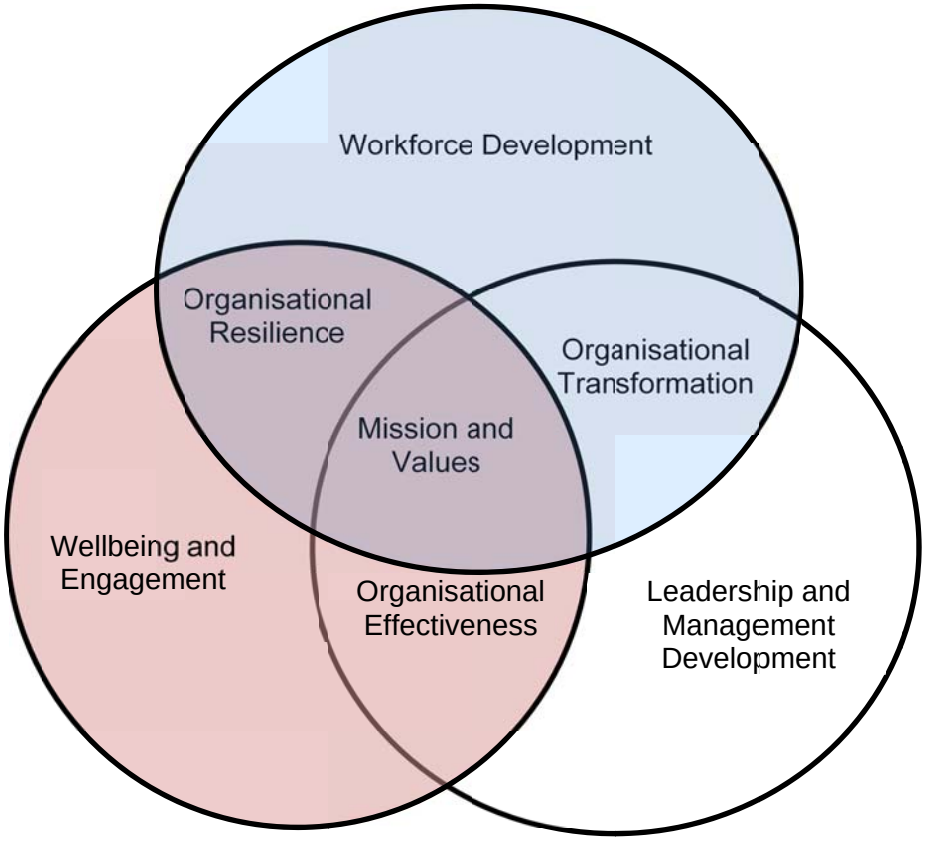
The development of new roles, capabilities and skills within the workforce is an essential element of any service transformation programme but this needs to be achieved alongside continually improving quality, productivity and performance. The continuous development of the workforce linked to service and financial plans must be key strategic Human Resource objectives. However, to really drive the change in the workforce, it will also require current and future leaders to be highly competent and be able to balance the complexities of the Clinical Quality/Effective Resource Management/Operational Performance agendas. Finally, for leaders and managers to be most effective and for services to remain resilient during transformation investment in staff well-being and engagement is important. This leads to 3 strategic workforce initiatives:

- **Workforce Development**: Designing, developing and recruiting a workforce based on service needs and available resources.

- **Staff Wellbeing and Engagement**: Building organisational, team and individual resilience through a proactive approach to engaging staff and improving their health and well-being.
- **Leadership and Management Development**: Developing and supporting current and future leaders and managers to ensure services are well led.

These 3 agendas cannot stand alone and the Strategic Human Resources Framework is designed to integrate them so the whole is greater than the sum of the parts. The integration will then support:

- Improved organisational resilience
- Leaders and managers being more effective
- Effective management of organisational transformation



The organisational outcomes from the above strategic workforce initiative are to:

- Ensure we have the Right People at the Right Time in the Right Place
- Improve Service Quality
- Improve Organisational Performance

In Appendix 1 the Strategic Human Resource initiatives are combined in a matrix with Organisational Outcomes to give a set of high level strategic objectives for 2015/2017. The matrix is designed to provide a summary Human Resource Strategy on a page with clear objectives for the next 3 years.

The Trust's Mission and Values have been embedded in a set of core HR processes. This has led to a deliberate Value Based Human Resource Management approach to underpin the way we develop, manage, lead and treat the workforce.

3. Supporting Workforce Strategies

The 2 key elements of the strategic workforce initiatives are Staff Engagement and Leadership and Management Development. These are crucial supporting strategies for service transformation to succeed.

3.1 Staff Engagement

There is clear evidence that an engaged workforce improves organisational performance and productivity in all employment sectors. The Francis report also identified that a disengaged workforce was an important part of why things went wrong at Mid Staffordshire Hospitals. This coupled with the importance of effective change management, means that Staff Engagement needs to be central to the way we lead and manage services and the transformation programme. The Staff Engagement Strategy, in Appendix 2, is designed to align the different ways we talk and listen to staff so the Trust can effectively harness the abilities of the whole workforce. Learning from high performing organisations in this area shows that a clear and simple model for Staff Engagement is a key to improving the Trust's engagement process. The Strategy defines what the purpose and aim is of staff engagement and sets out an improvement plan for the next 3 years.

The key issues of the Staff Engagement Strategy are:

- At the heart of staff engagement must be committed to delivery of the Mission and Values.

- Staff Engagement must be an active process (it is a "contact sport")

- There are 4 essential elements to effective staff engagement:

    - Visibility of senior leaders
    - Engaging Leaders and Managers
    - Everyone feeling they have a voice and will be listened to
    - Living the value

- The Trust is already doing a lot of things right in staff engagement so the strategy is not about re-inventing the wheel but better alignment

- A clear staff engagement model will align current activities

- There is a strong and clear link between staff engagement and well-being and the survey results will help the Trust to identify areas of good practice and where further support is required

- Staff engagement needs to be a core competency for Trust leaders and managers

The Staff Engagement Strategy finally sets out key actions for each element of the model.

3.2 Leadership and Management Development

There is no question, as the CQC have identified, that to deliver safe, effective, caring and responsive services they must be well led. Good and effective leaders and managers are an essential part of high quality services and key to achieving the service transformation programme required to meet the financial challenges facing the NHS and public services. The Leadership and Management Development Strategy, in Appendix 3, is designed to ensure that we have the right investment in the development and support for current and future leaders.

The Trust has been working closely with the Swedish community in Jonkoping where they have been able to achieve one of the best health outcomes in the world at one of the lowest costs in Sweden. They have used a system approach to care based on the work of Dartmouth College in the USA and the Trust has adopted this as the basis of their leadership and management arrangements. The Leadership and Management Development Strategy is designed to

support a System Leadership Model underpinned by the Trust's Values. The key elements of the strategy in summary are:

- The aim of the Strategy is to attract, retain and develop high quality leaders and mangers

- The strategy will develop the current leadership and management competencies into a system approach linked to the Micro, Meso, Macro and Meta levels as described in "How the Organisation Runs"

- Developing a model through an extensive engagement process where the Trust's Values are used to describe Leadership Behaviours

- 360 degree appraisal becoming a regular development process for senior managers

- Development Centres to support leaders and mangers individual and collective development needs

- Systematic and consistent approach to Coaching and Mentoring

- Developing models for Talent Management and Succession Planning linked to key strategic objectives, including a focus on clinical leaders

- Middleground to remain an on-going key communication and engagement vehicle for senior clinicians, managers and leaders with the Trust Board

- Leaders and managers should role model the Trust's values

The Strategy sets out a 3 year high level plan for the continuous investment in the development of high quality leaders and managers.

Alan Davis
Director of Human Resources and Workforce Development

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South West Yorkshire Partnership NHS
NHS Foundation Trust

STRATEGIC HR FRAMEWORK 2015/2017: STRATEGY ON A PAGE

Organisational Outcomes / Strategic HR Priorities	Right People Right Time Right Place	Enhancing Service Quality	Improving Trust Performance
Workforce Development	Development of a robust model of Workforce Plans linked to the Service Transformation Programme, 5 year plan and BDUs annual plans including development of new roles	Development of Clinical Support Workforce through: • Care Certificate • Clinical Apprenticeships • Redesign of Band 1-4 clinical workforce	Develop a reward model to align Pay and Performance, including senior managers pay, linked to the Trust's strategic goals
Wellbeing and Engagement	Development of a resilient workforce through proactive Staff Health Promotion and leading edge Occupational Health and Wellbeing Services	Ensure effective and regular wellbeing and engagement feedback systems are maintained and used to develop Key Performance Indicators	Development and Implementation of Staff Engagement Strategy
Leadership and Management Development Strategy	Talent management programme and succession planning for key organisational roles Development centres to identify talent and agree personal development plans	Develop programmes to support the development of current and future Clinical Leaders Development Support for New Leadership and Management Structures at micro and meso system levels	360º Appraisal for Senior Managers Developing Leadership and Management Competencies based on System Leadership model
Values Based HRM	Value Based Contracts of Employment	Value Based Recruitment and Induction Value Based Leadership Behaviours	Values based appraisal

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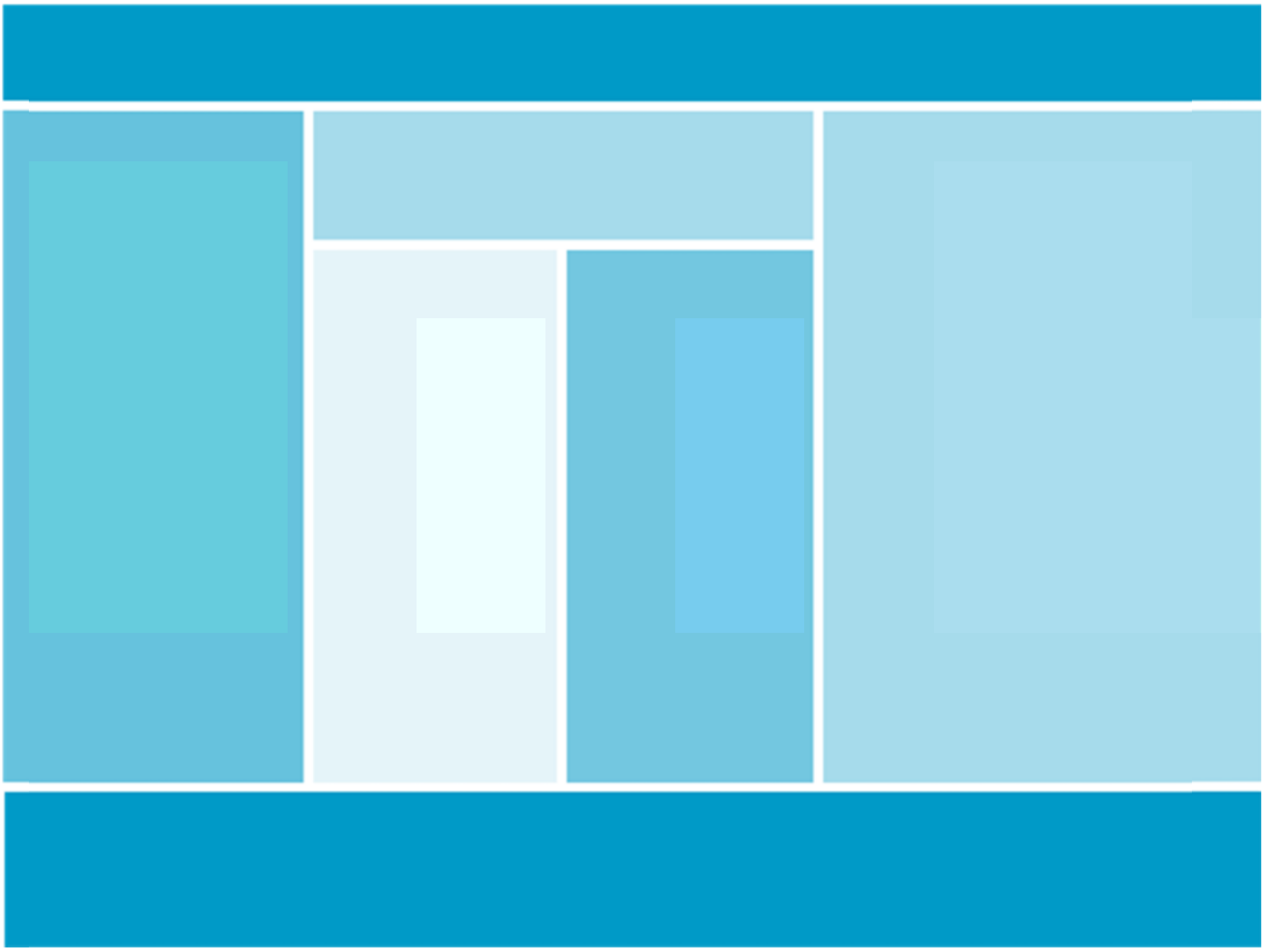
NHS Foundation Trust

Staff Engagement Strategy

2015-2017



Introduction

Values based approach to staff engagement

South West Yorkshire Partnership NHS Foundation Trust is a partnership organisation, committed to engagement and involvement across all stakeholder groups. Staff engagement is essential if the Trust is to achieve its mission of enabling people to reach their potential and live well in their community.

The Trust's values were developed through a comprehensive engagement process with staff, service user and carers and resulted in a set of statements that underpin the way we work internally, the service offer to local communities, and our approach to partnership.

Our values:

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

The Trust's mission and values are the foundation for the Trust's staff engagement strategy. The Trust is committed to becoming a high performing organisation in relation to staff engagement which will drive the future success of the organisation.

What is Staff Engagement?

South West Yorkshire Partnership NHS Foundation Trust is committed to developing an engaged workforce with everyone demonstrating the Trust's values in what they do.

The Trust's definition of Staff Engagement is 'A systematic approach to ensuring that the whole workforce is committed to delivering the Mission and Values of the Trust'.

The Trust recognises the following essential elements of effective staff engagement:

- Visibility of senior leaders
- Engaging leaders and managers
- Everyone in the organisation has a voice
- Everyone in the organisation lives the values in what they do

Staff Engagement is everyone's responsibility within the organisation. It is a 'participation sport' and contact sport in which leaders/mangers and all colleagues within the Trust must engage in a two way process of dialogue to support service improvement and development.

Why is Staff Engagement Important?

The Trust recognises the critical importance of staff engagement to the success of the organisation and the achievement of key objectives. There is a strong correlation between engaged employees and organisational performance and productivity across all sectors.

In the NHS it has been shown that high levels of staff engagement lead to better patient outcomes and more effective use of resources. This strategy describes the ways in which the Trust will promote and foster employee engagement as a key enabler to deliver improving services and ensure that the Trust remains a successful and sustainable organisation.

Staff engagement is also essential to the achievement of the Trust's quality priorities, again developed in partnership with staff, service users and carers, which set out 7 key aspects of service, including a commitment to a range of initiatives and support to ensure our staff are 'fit and well to care'.

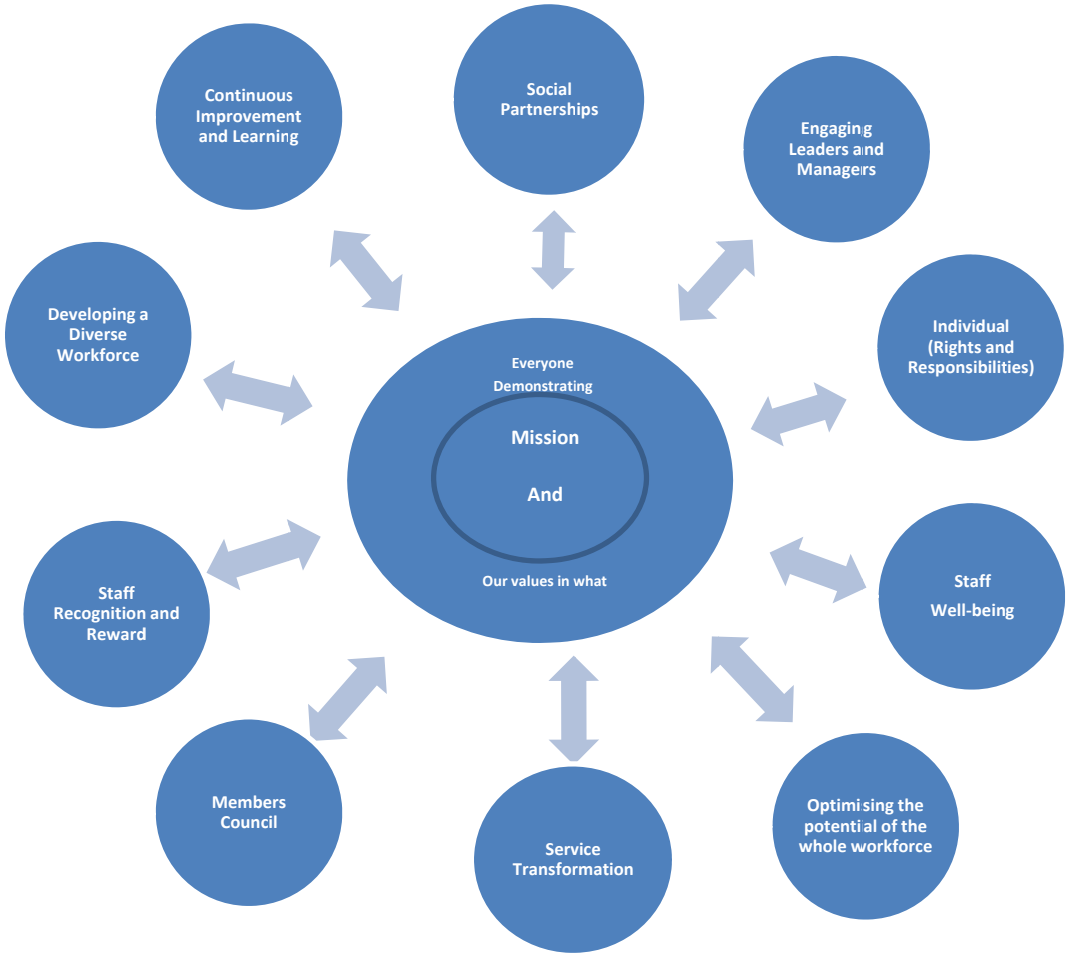
The Trust's service transformation programme will only be successful if it is built on sustained employee engagement where the views of all stakeholders shape the future direction and delivery of the service. Staff engagement will support staff to work in new ways and ensure that we improve service quality through a shared understanding of plans and priorities. A key element of employee engagement includes recognition and valuing individual employees and teams.

The Trust has been for a number of years investing in staff engagement initiatives. The key objectives in the development of this strategy are to:

- Create a model for Staff Engagement which aligns better what we are doing now and identifies any gaps.
- Provide a clear purpose for staff engagement activity which is an essential component of a high performing organisation.
- The strategy is not a comprehensive list of activities but a framework to promote sustainable Staff Engagement.
- To make clear that Staff Engagement is everybody's business and identify the key processes by which the Trust will promote staff engagement

This strategy will identify the key dimensions of staff engagement, how the organisation will promote staff engagement and will identify the key actions to implement this strategy.

The Trust's model of Staff Engagement



The Trust's model of Staff Engagement recognises there are a number of existing processes which support staff engagement across the organisation. These dimensions of staff engagement need to be strongly aligned and the feedback gathered through these processes needs to be reviewed at an organisational and service level to drive continuous improvement.

The Trust's Mission and Values are the foundation for the Trust's approach to staff engagement. Everyone in the organisation must actively demonstrate the values in what they do in enacting the Trust's Mission.

The Trust's leaders and managers have a prime responsibility for staff engagement and this will be a key focus of the action plan.

When developing the Trust's staff engagement model it became clear that two issues were not fully addressed. Firstly, it is recognised that staff recognition and reward is a key element of effective staff engagement. Secondly, the rights and responsibilities of all colleagues working in the organisation to not only work within an environment where staff engagement is valued but also to actively engage in service change and development.

The Trust's values include 'honest, open, and transparent'. Service transformation and the organisational change that will result require everyone to engage in honest open and transparent conversations that will support service improvement.

A key element of the model is the Trust's partnership working arrangements with staff side representatives which has been critical to the development of the organisation. The Members Council is also a key process for supporting staff engagement through elected staff representatives and an appointed staff side representative.

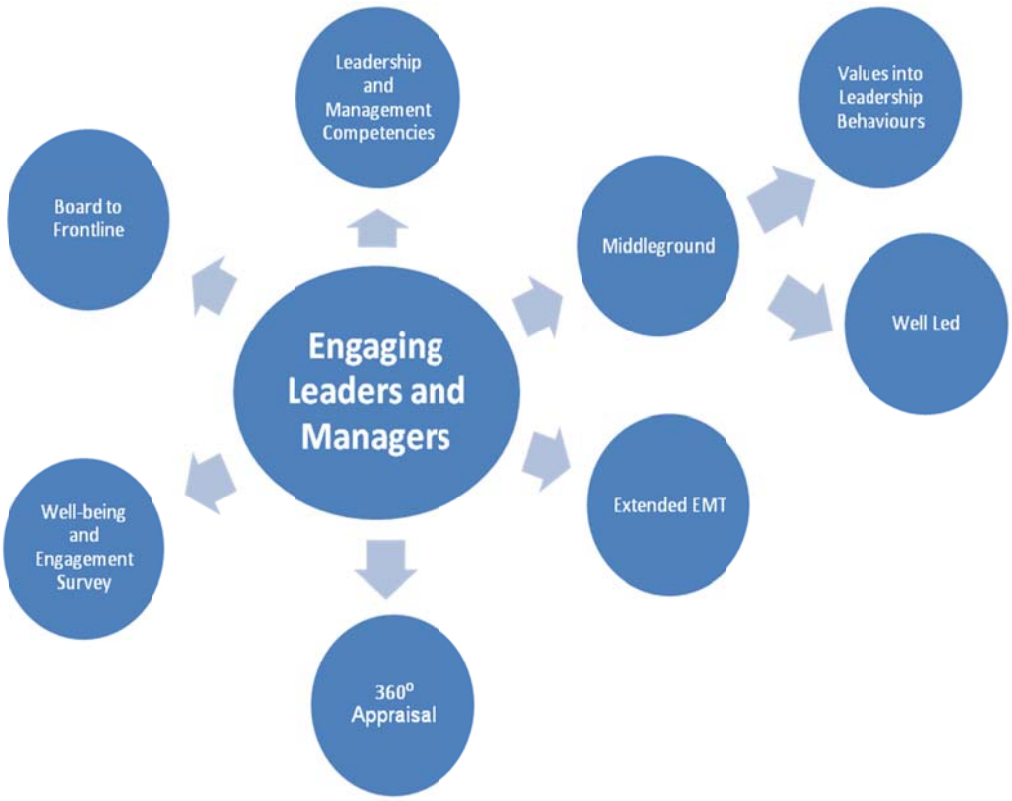
The Trust's key workforce priorities such as supporting improvements in well-being and resilience, developing a diverse workforce and optimising the potential of the whole workforce will be delivered through engaging with colleagues across the organisation.

The Trust will regularly review the effectiveness of these processes using feedback gained through staff engagement events and survey feedback.

The Key Enablers of Staff Engagement

As detailed in the staff engagement model the Trust will use the following key enablers to promote a culture of staff engagement and involvement:

Engaging Leaders and Managers



The Trust's leaders and managers are critical in the development of a culture in which staff engagement and involvement is seen as fundamental to the delivery of a high quality service. Being an effective leader and manager within SWYPFT requires the delivery of both technical skills and competencies but also the ability to actively engage with colleagues promoting a culture of high performance to achieve key service objectives.

Staff Engagement is a key objective for all leaders across the organisation. Leaders and managers have the prime responsibility for the development of a culture which encourages and values staff engagement and communication. The Trust's leadership and management development strategy aims to ensure that we attract, retain, reward and develop high quality leaders and managers which are essential for the delivery of safe, effective, responsive, caring and well-led services.

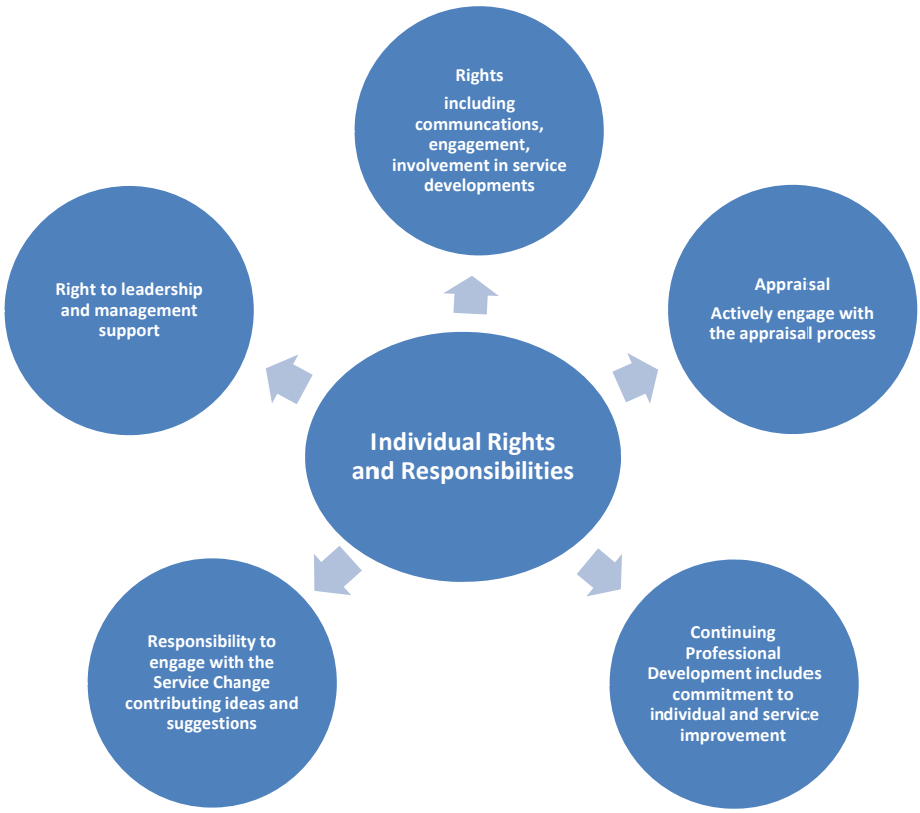
The Trust's senior team will ensure they oversee engagement processes within their areas of responsibility and that there are clear mechanisms for feedback from frontline services to the Trust Board.

The Trust is developing leadership and management development competencies reflecting the systems leadership model. The Middleground programme and Extended Executive Management Team are key enablers of staff engagement for leaders and managers. The Middleground programme is being used to develop leadership and management behaviours aligned to the Trust's values and also definable observable behaviours for all colleagues.

What next?

- The Trust's Leadership and Management strategy will be agreed by the Trust Board. This will include staff engagement and involvement as a key element.
- Trust Directors' objectives will include staff engagement
- Leaders and managers will be supported to develop their competencies around staff engagement and communication
- The Trust's Middleground programme will be used a key communication and engagement tool and a key tool to further develop a culture of staff engagement
- The Trust Board will ensure staff feedback is received from 'Board to Ward'
- Trust Directors will ensure they have regular engagement with clinical teams
- Leaders and managers across the Trust will review feedback on staff engagement and take actions as necessary.
- All colleagues have the opportunity to give feedback and suggestions as to how staff engagement can be improved within their service area.

Individual (rights and responsibilities)



The Trust recognises that staff engagement is a two way process involving active involvement of leaders/managers and colleagues working jointly to develop and improve services for service users and carers.

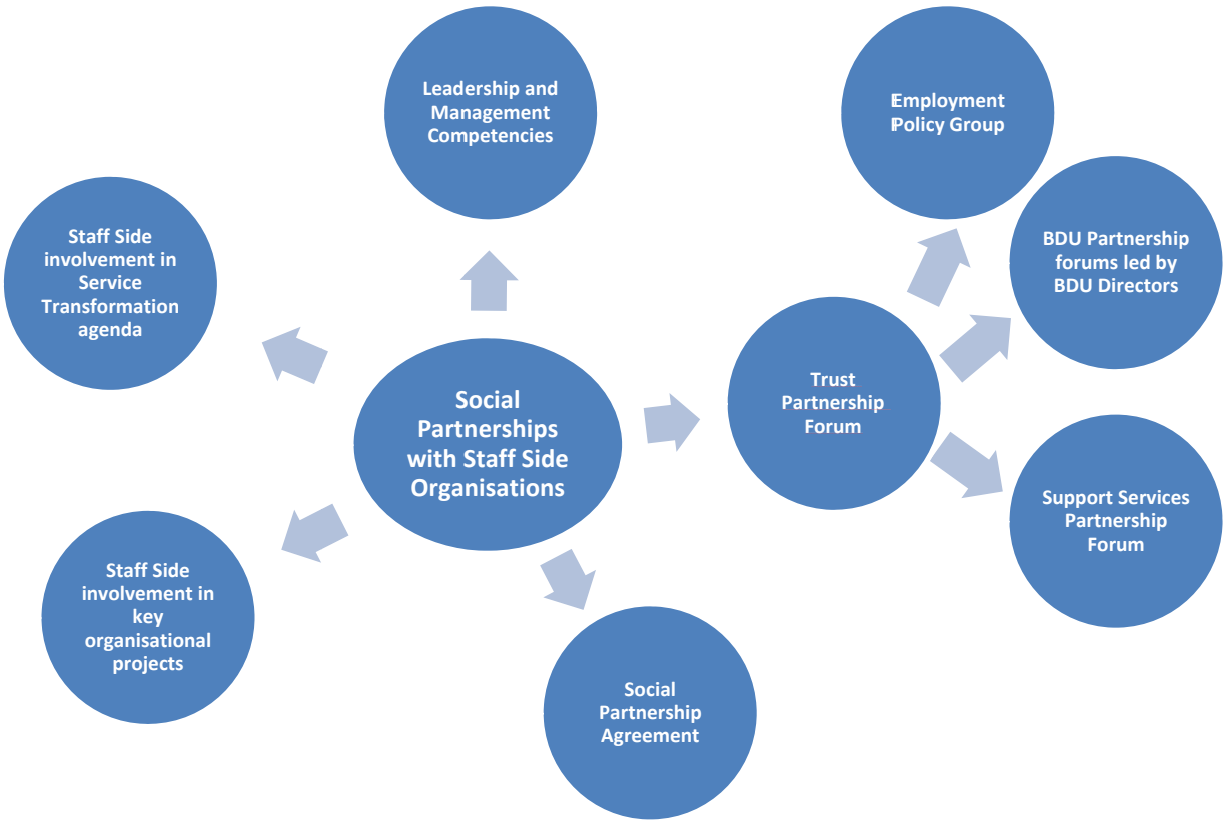
If the Trust is to achieve the benefits of employee engagement everyone must adopt the values and behaviours which promote an involvement culture. Employee engagement is a shared responsibility between employer and employee.

All individual colleagues have rights within the workplace for example to be subject to the Trust's employment policies, to receive leadership and management advice and support, to be involved in team and service developments etc. With individual rights also come responsibilities as detailed in the Trust's contract of employment and employment policies. This strategy recognises the responsibilities of all colleagues to actively engage in the development of their team and service, contributing their ideas and suggestions for improvement.

What next?

- Continue to develop the Trust as a modern progressive employer committed to best practice in workforce development. Use feedback from the well-being at work review, NHS Staff Survey, Investors in People accreditation etc, to support action planning.
- Encourage all colleagues to engage with the service development activity as part of their role.
- Encourage the use of staff suggestion schemes.
- Using the Trust's Middleground programme define observable behaviours based on the Trust's values to encourage staff engagement.

Social Partnership with Staff Side organisations



The Trust's Social Partnership Agreement provides a commitment to positive employee relations and partnership working which aim to create a culture where managers and staff side organisations work in partnership to ensure staff fully utilise their knowledge and skills to improve the delivery of care.

The Trust's Social Partnership Forum and BDU Partnership Forums will be used to review levels of staff engagement across the service and to support the implementation of this strategy. Staff Side representatives are able to play a key role in supporting the organisation to identify areas of good practice and areas for development around staff engagement.

What next?

- The Trust's Partnership Forum will support the implementation of this strategy and support the feedback and evaluation process.
- BDU Partnership Forums to review progress in developing a culture of staff engagement within their area of service on a regular basis.
- BDU Partnership Forums will ensure that organisational and service change is managed in a way which promotes staff engagement and involvement.

Staff Well-Being and Resilience

It is recognised that staff engagement and involvement in decision making is a key element that contributes to staff well-being and resilience. The Trust has been working with Occupational Psychologists Robertson Cooper, specialists in employee well-being, for a number of years and has invested significantly in occupational health and well-being services. A key aim is to improve employee well-being, supporting staff to remain in work whilst managing their individual health issues and reduce the impact of non-attendance.

The Trust's well-being at work partnership group includes senior managers and staff side representatives who oversee the implementation of these work streams. The Trust's Well-being at Work Review is a key engagement tool to gather feedback to support improvements in employee well-being, resilience and engagement. The well-being questionnaire includes key questions around staff engagement and involvement. Following each review a series of well-being and engagement forums are arranged for colleagues to discuss the latest results and discuss possible solutions.

What next:

- Continue to seek feedback from staff through the well-being survey on a regular basis, this will inform the action planning process
- Use well-being at work engagement groups to discuss the results of the well-being survey and discuss potential solutions
- All service areas review their well-being and engagement results to support action planning.

Optimising the potential of the whole workforce

A key aim is to ensure that everyone is able to fully contribute to service improvement initiatives and is supported in their development.

The Trust's key employment policies and practices such as induction, appraisal, access to learning and development are used to encourage active staff engagement and participation in the development of the service.

The welcome events are used to encourage colleagues new to the organisation to help the Trust live the values every day. *Fresh Eyes* is all about new starters at the Trust looking at the organisation from a fresh perspective and telling us what we are doing well and where we could improve. This process encourages new entrants to contribute their ideas and actively participate in discussions around improvements to the service.

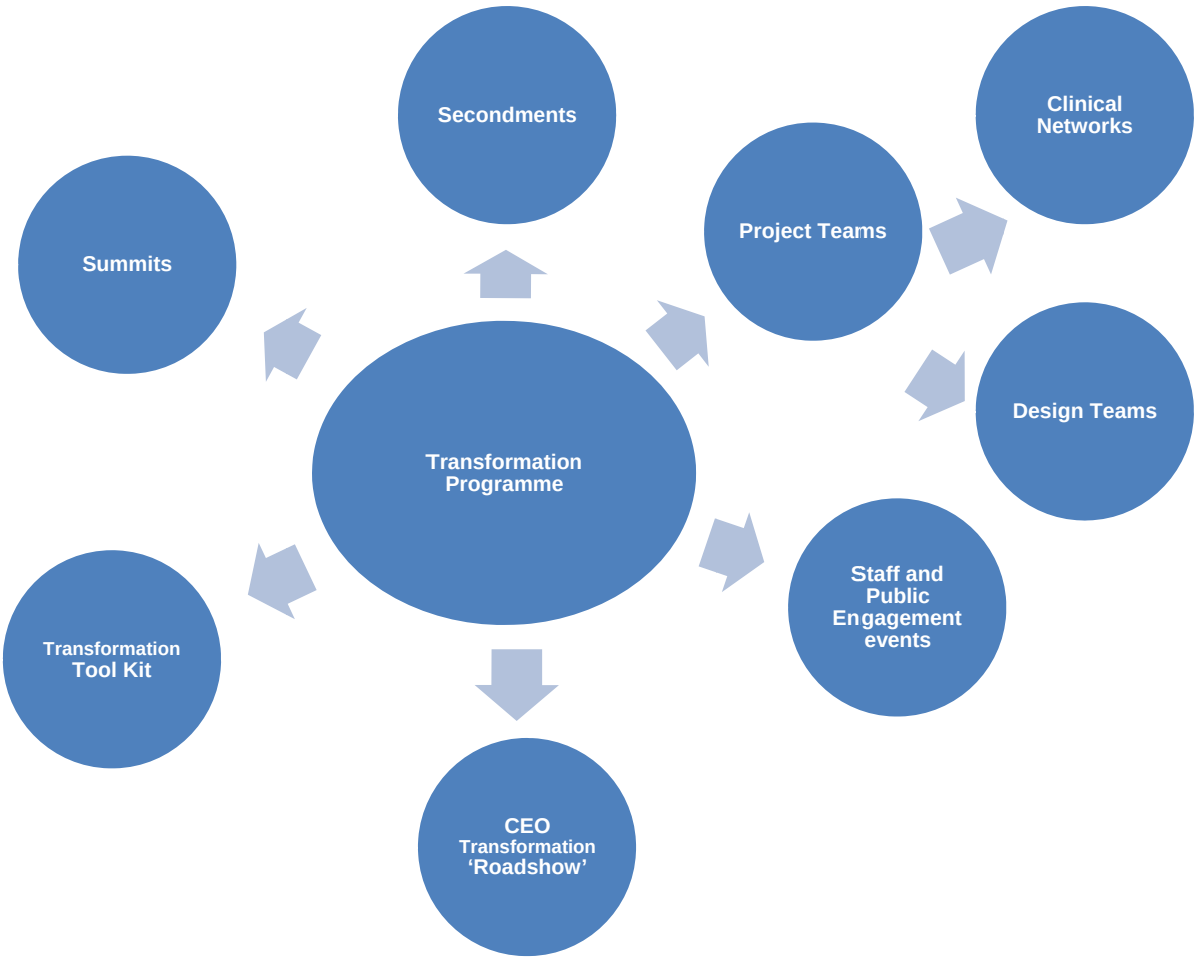
Vales based appraisal is a key vehicle for ensuring staff engagement. Objectives and behaviours that support staff engagement can be reviewed within the appraisal process. Feedback can be gained as to the effectiveness of staff engagement processes and whether these are seen as helpful and allow colleagues to contribute fully.

A key challenge for the organisation is creating the space and time for engagement activities. The Trust will need to use different processes such as workshops, project groups but also use day to day activities such as supervision sessions, handovers, team meetings etc to promote and deliver staff engagement at a team level.

What next?

- All staff are encouraged to be involved in the development of the service at a level appropriate to their role.
- Learning and development opportunities support this aim.
- The Trust's induction and appraisal processes are used to encourage active staff engagement.
- Staff suggestions and ideas are considered and where appropriate support is provided for these to be taken forward.
- There are systems in place to recognise talent within the Trust's workforce and to support succession planning.

Service Transformation



The service transformation workstreams has involved working together within our communities, our partners, service users, carers and staff. Staff involvement and engagement is essential if we are to develop a truly sustainable model of service that fits the needs of people moving forward. Clearly, there is a need for open, honest and transparent communication.

The transformation programme involves colleagues in many ways. The primary route is through direct involvement in a project. This may be as part of a project team, or part of a wider clinical network, which acts as a 'sounding board' for the project team, or formal involvement in a design team which develops and evaluates options for the future configuration of services. Some colleagues are formally seconded to undertake transformation work – usually for 12 to 18 months.

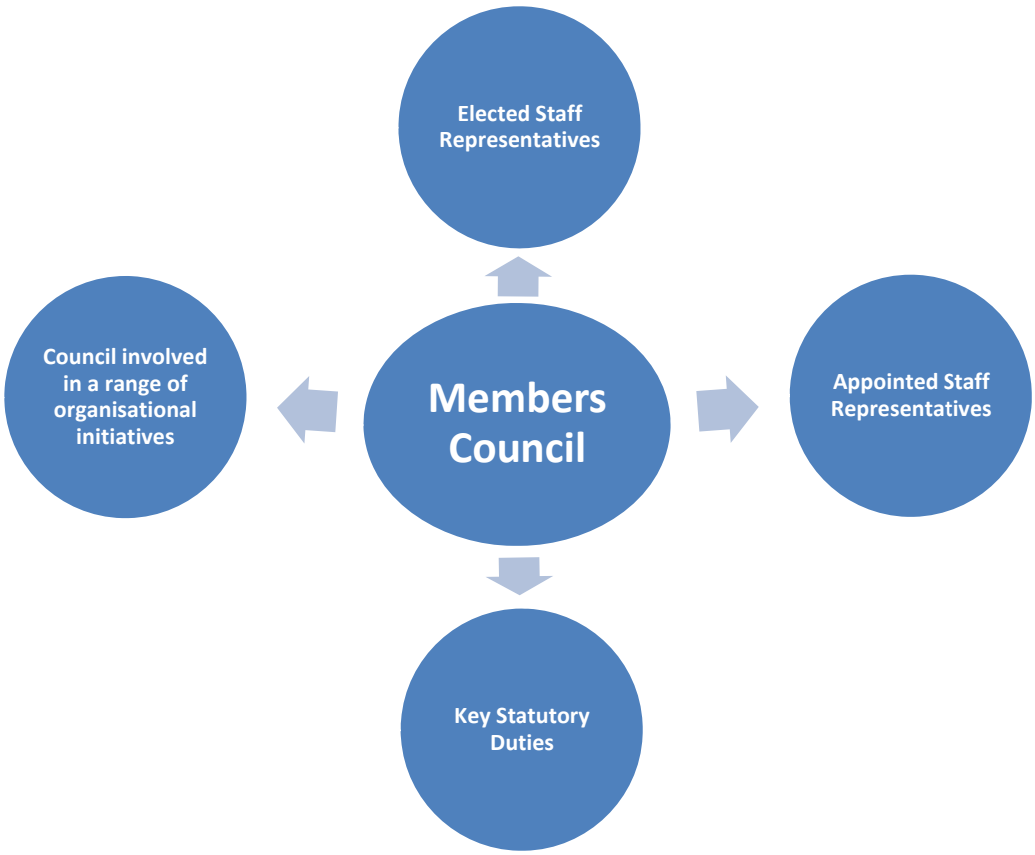
We also hold large scale staff and public engagement events to test what people want, think and feel, and to feedback on progress. These events are supplemented with sessions usually led by the Chief Executive which are entirely focused on staff and transformation. These 'roadshows' offer all staff the opportunity to talk about what transformation means for them and to ask questions of senior leaders involved in the transformation programme. These sessions take place at venues across the Trust's geography to encourage participation.

All of these approaches are supported by the Trust's Transformation Tool Kit – this is a guide to the methodology that we use for transformation projects and contains lots of tools, template and supporting materials to ensure we deliver change effectively. A key part of the Tool Kit is the engagement and involvement of colleagues and other stakeholders.

What next?

- Each transformation workstream will develop a staff engagement plan which will be reviewed on a regular basis
- Provide different ways in which to involve staff so that all staff have the opportunity to be engaged with the transformation process
- Work in partnership with Staff Side colleagues on the service transformation programme seeking their feedback and input as a key stakeholder
- Seek regular feedback and improvement in the engagement process

Members Council



The Trust's Members' Council is made up of elected representatives of members and staff, and also of nominated members from key local partner organisations. The role of the Members' Council is to ensure the Board of Directors is accountable to our local communities.

The Members Council supports staff engagement by inviting members of staff to make a nomination for one of the staff elected seats on the Members' Council. This includes elected seats for medicine and pharmacy, nursing, non-clinical support and allied health professionals. In addition, the Trust's staff side organisations have an appointed seat on the Members Council.

The Members Council meets quarterly with the Trust Board in attendance. The Council has a range of functions such as leading on the Chair's appraisal with Deputy Chair, responsible for appointing non-executive directors and appointing the Trust's external auditor. Council representatives are also involved in a range of organisational initiatives such as the 15 Steps Challenge, mock CQC visits and co-production of the Trust's mission and values.

What next?

- Continue to support staff representatives and staff side representative to be active members of the Council.
- Seek feedback from representatives as to how they can be further supported in their role.

Staff recognition and reward

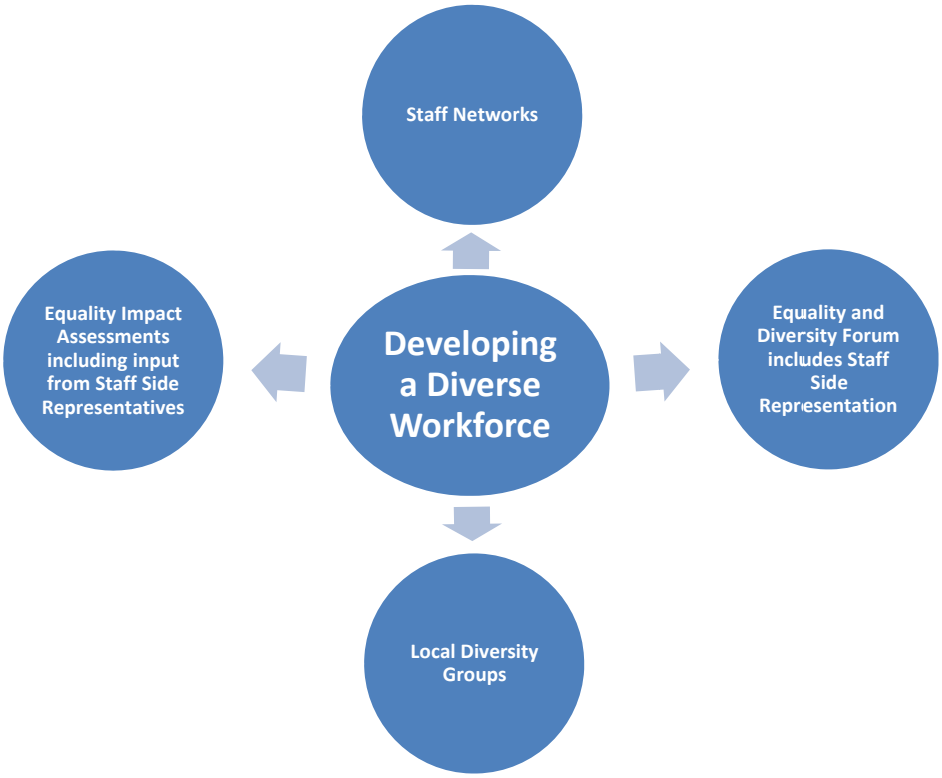
Recognition and reward is an essential element of staff engagement. Recognition can include formal Trust schemes such as the Values into excellence awards and long service awards and informal day to day praise by service and team managers. It is vital that staff receive recognition and acknowledgement. Feedback from staff indicates that feedback and recognition from their manager is extremely important and supports employee motivation and the sense of feeling valued. The Trust's appraisal process also enables formal recognition of colleagues' contribution in the workplace.

The Trust is committed to ensuring that its reward schemes are implemented fairly and consistently in line with national and local policies. The agenda for change agreement has been implemented in partnership with staff side organisations.

What next?

- Review the Trust's arrangements for staff recognition including formal schemes and also informal feedback using the well-being at work review and investors in people feedback through internal reviews.
- Leadership and management competencies to include staff recognition

Developing a diverse workforce



The Trust's Equality First Strategy for promoting a fairer organisation recognises that Equality and Diversity is not an add on but is central to all we do as a Trust, as both a provider of services, as an employer and as part of the public sector with a further duty to positively promote diversity and equality.

The Trust has an Equality and Diversity Forum chaired by a non-executive Director, this includes staff side representation. The Trust's Equality Report sets out the Trust's goals for equality for the next three years. Based on the report, the Trust has decided to focus on two protected characteristics for staff, service users, their families and carers; 'race' and 'religion or belief'. We will focus on these areas to ensure that our organisation is an equal and fair place to work or receive care.

There are also local diversity groups which identify key equality and diversity priorities within Business Delivery Units.

The Trust will ensure that:

- The Equality and Diversity Forum will ensure this agenda is informed by active staff engagement
- Ensure that all individual colleagues and/or groups of staff receive appropriate support in order to fully engage with their team, service and the wider organisation. These issues should be fully considered in line with the Trust's policies.
- Promote the use of equality networks as an enabler for staff engagement and involvement
- Continue to involve staff side organisations as key stakeholders in delivering the equality and diversity agenda.

Continuous Improvement and Learning

The Trust is committed to continuous improvement and learning around the implementation of this strategy which will include feedback gained through the well-being and engagement survey, NHS Staff Survey and also external reviews such as Investors in people accreditation, and the well-led audit.

There are a range of indicators which will be used to evaluate the implementation of this strategy, these include:

- Survey feedback from the Well-being at Work Review, administered by Robertson Cooper, this provides staff feedback on perceptions of employee well-being, engagement and resilience. NHS Staff Survey results which includes a measure of overall staff engagement.
- Feedback from the Well Led audit
- Investors in People reviews. Standard 7 of the Investor in People framework focusses on involvement and empowerment.
- Feedback gathered through the NHS Staff family and Friends Test.
- Feedback from staff on the implementation of the service transformation programme.
- Feedback gathered though individual and team 360 appraisal.

The feedback gained through these indicators will be used to review and evaluated the implementation of this strategy.

Conclusion

The actions identified above will be taken forward in the delivery of this strategy during 2015-2017.

A well-being and engagement annual report will be produced highlighting key survey feedback and describing key actions that have taken place over the previous 12 months.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Leadership and Management Development Strategy 2015/17

Human Resources Directorate

Version 2.14

Contents

Introduction

The provision of high quality healthcare services to the local populations the Trust serves is built upon the commitment and capabilities of the current workforce. The challenges facing the Trust, now and in the next few years requires different and new ways of working to ensure services remain relevant for today and ready for tomorrow.

Leaders and Managers have a key role in ensuring this occurs in a manner consistent with the Trust's Mission and Values, Service and Financial Plans, and its responsibilities as a public sector body. This is not an easy task given the rising expectations from the people who use our services and the significant cost pressures across all of the public sector. Therefore, Leaders and Managers must have clarity about these responsibilities and expectations and have the capability and support to lead and manage services within a complex and challenging environment.

The Leadership and Management Development Strategy sets out the organisation's commitment to ensuring that the Trust is well led, that Leaders and Managers are valued and they are able to demonstrate the Trust's values through investment and support in their development.

Good and effective leaders and managers are an essential element to delivering the highest quality of services within available resources and investing in their development will enable excellent healthcare, now and in the future through their skills, passions and talents.

Our Vision:

Enabling people to reach their potential and live well in their community.

Our values:

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

Our Leadership Aim:

To ensure that we attract, retain, and develop high quality Leaders and Managers essential for the delivery of safe, effective, responsive, caring and well-led Services.

Our Leadership and Management Development Strategy:

The purpose of our Leadership and Management Development (LMD) Strategy is to outline and summarise the over-arching arrangements we have or are putting in place in the development of both leadership and management practices across the Trust, resulting in improved healthcare for Patients and Service Users.

Our Definitions:

There are many definitions of both leadership and management and of the terminology used within each one. We have adopted a list of terms to ensure clarity and consistency in our approach, listed at Appendix A. In short, Leadership refers to the preferred behaviours adopted in influencing ourselves and our colleagues across our systems, whilst Management is deemed to be the effective and efficiency use of resources, including staff, premises, equipment, finance, information, policies and processes.

Our Intentions:

Our Mission and Values specify what the Trust aspires to achieve in all its undertakings. Our Mission gives clarity about what services we need to provide to the people who use them. Our Values give clarity on the way we need to deliver our services. Combined, they challenge us to ensure that we are well-led in the way we do so. In response, we are developing and embedding both 'Systems' and 'Values-based' Leadership and Management practices across all our Services.

Our *'5-year Strategic Plan'* sets out how we intend to deliver our goals. In *'How the Organisation Runs - parts 1 and 2'* (see Appendix B), we have set out the broad framework for achieving our intentions. Each of the aforementioned key documents forms the foundation of our approach.

Through our '*Leadership and Management Development (LMD) Strategy'*, we aim to ensure that we attract, retain and develop high quality Leaders and Managers essential for the delivery of safe, effective, responsive, caring and well-led services. We are committed to developing leaders and managers who create and facilitate environments where safety is maintained and quality of care is improved through innovation. This will result in transformed, efficient and effective services.

Our ethos is drawn from cutting-edge research and best practice in the development of *'Systems Leadership'*, both internationally and in the UK. Specifically, from research undertaken by Dartmouth College in the USA. This research is providing evidence that success in both transforming and improving healthcare provision together comes from developing effective clinical microsystems systems. It also draws upon shared learning from the integrated systems working approach adopted across health, social care and the wider public sector in Jönköping, Sweden. This approach has successfully demonstrated the ability to deliver high quality healthcare outcomes at lower cost.

It further draws from the research and best practice in *'Values-based Leadership'*. A key element of effective leadership and management is employee engagement, which has a strong correlation to organisational performance and productivity across all Sectors. The *Francis Report* highlighted that poor leadership and a disengaged workforce were important factors in what went wrong. We will mitigate against this by ensuring that the behaviours of staff align with the Trusts *Values* and are role-modelled by Leaders and Managers. In doing so, we will ensure that all Staff are able to contribute their views, in particular the involvement of Leaders and Managers in developing a behavioural framework. Each of the aforementioned approaches will be undertaken in keeping with our 'Staff Engagement Strategy' (aligned document.

To achieve this, we will define what a Leader and Manager in SWYPFT means, including what is unique about being a Leader and Manager in this Trust. This will be undertaken with the engagement of Leaders and Managers within senior roles across the Trust as part of *our 'Staff Engagement Strategy'* (see aligned document o). It will involve 500+ senior Clinicians, Managers, Staff-side and Support Services to develop leadership and management behaviours aligned to Trust Values. In doing so, we will define the observable behaviours for all Individuals; Teams; Leaders against each of the 6 x Trust Values.

Our Current Leadership and Management Arrangements:

The Care and Clinical Systems that we are currently working to further develop and embed across the Trust comprise the alignment of Micro, Meso, Macro and Meta Systems, illustrated as follows:

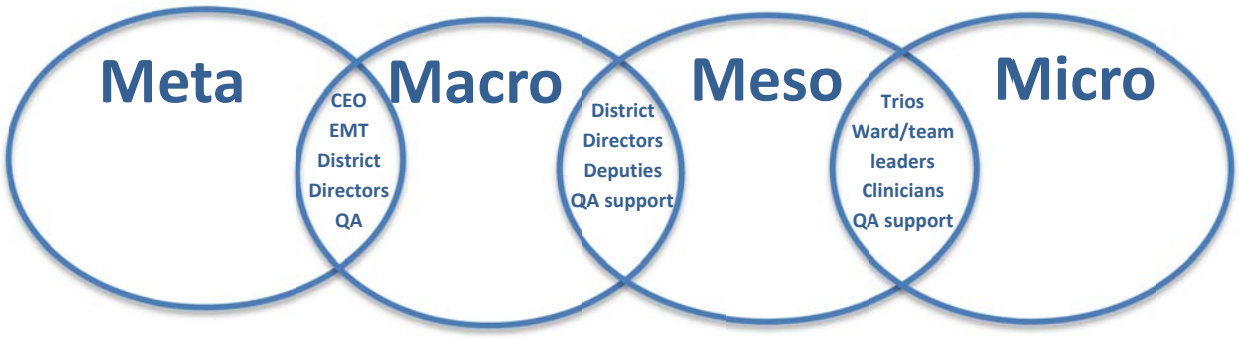


Fig1

Each System includes formal Leadership and Management roles, with defined responsibilities and accountabilities, referred to as the 'Management System' for each Service. This includes developing Collective and Collaborative Leadership arrangements within all 4 of our Systems.

Leadership is enabled formally, through each role and associated responsibilities, including: Chair; Chief Executive; Executive Directors; Non-Executive Directors; District and Quality Academy Directors; Deputy Directors; Clinical Leads; General Managers; Practice Governance Coaches (collective called TRIOs); Service and Project Managers, Ward and Team Managers/Leaders and Supervisor. It is also enable informally through values-based behaviours adopted by all Staff across the Trust, individually and within Service Teams.

Management is arranged formally through each role and associated responsibilities, reflected in job descriptions for each role and reflected in organisational structures chart(s) for each System and Service.

Our Leadership Challenges:

The current key leadership challenges faced by Leaders and Managers across the Trust include the following:

- ❑ Developing greater resilience in a time of great uncertainty, change and dwindling resources
- ❑ Managing risk and influencing change in service delivery whilst maintaining safety, improving quality and meeting multiple compliance requirements
- ❑ Developing and embedding our recently revised management structures across clinical services through transformational change to improve these services
- ❑ Improving and managing relationships both within and out-with the Trust, resulting in improved staff morale and well-being and enhanced confidence in our ability to deliver our services
- ❑ Finding, developing and retaining Talent to aid succession
- ❑ Enhancing our business acumen to ensure retention of contracted services and winning new business

Our Approach in Developing Competent Leaders and Managers:

Our commitment to developing the capabilities of our Leaders and Managers is reflected in the significant investment we've made in implementing the first phase of *'How the Organisations Runs'* (see aligned document i). The next phase has a number of priority LMD activities arising from the aforementioned current challenges and which includes the following:

No.	Priority
1	To clarify and define the role and capability requirements of Leaders and Managers within our 4 x preferred Management Systems
2	To further develop, share and embed *'Systems Leadership'* and *'Values-based Leadership'* across the Trust and develop relevant measures to demonstrate the impact and improvements
3	To develop the Trusts *'Values'* into agreed Behaviours
4	To further develop the capability of Managers to: *assess risk; facilitate transformational change; better manage relationships; foster innovation and service improvement; identify and develop talent; ensure safety, quality and compliance; enhance business acumen; manage agile working.* To reflect this in a *'Competency Framework'* for Leaders and Managers
5	To ensure a corporate programme of LMD activities that meets our identified education, learning and development needs to enable us to meet the aforementioned leadership challenges.
6	To identify and foster *'talent'* and ensure appropriate *'succession'* arrangements, enabling us to 'grow' our own staff across a range of clinical / medical / nursing and general management functions, and reflected in a diverse cultural workforce.

Fig 2

We plan to meet these priorities through a Trust-wide programme of planned support to Leaders and Managers (see Appendix b), which includes the following current and emerging LMD activities:

Leadership and Management Competency Framework – by reviewing and further developing our current leadership and management competencies to better reflect the System Leadership model in *'How the Organisation Runs – Part 1 and 2'*. From this, we will redefine the specific competencies for Leaders and Managers in our Micro, Meso, Macro and Meta systems. These competencies will be embedded into our leadership and management practices via the following activities:

Annual Appraisal – by embedding LMD competencies into performance and development discussions during annual appraisal in order to identify the individual needs of leaders and managers, devise personal development plans and to inform the corporate LMD programme, thus ensuring appropriate support and provision of development opportunities.

360-feedback – by offering all senior Managers an opportunity to benchmark their individual effectiveness and capabilities as Leaders, including receiving feedback from their respective Managers, Peers and Key Stakeholders. We will do so using one of several licensed 360-feedback tools. This will be provided via a rolling 3-year programme to all senior Leaders and Managers. 360-feedback will also be available to staff identified under our 'talent' arrangements via a programme of Development Centres.

Development Centres – by giving all senior Managers an opportunity to attend a tailored workshop at which they have access to 360-feedback, psychometric instruments and other development tools in order to review their current capability and practice to inform a personal Leadership and Managment development plan. There will also be an opportunity for all staff identified under our 'talent' arrangements to attend the programme of Development Centres.

Personal Development Planning – by giving all Managers protected time to identify their specific LMD needs. Also to receive advice and guidance about LMD opportunities and support in order to establish a personal development plan.

Education – by giving leaders and managers the opportunity to undertake formal educational programmes and qualifications that support identified organisational and service needs and/or individual development needs. We will do so by further developing our relationships with key providers, including the NHS Leadership Academy, Universities, Colleges and other specialist providers.

Training and Development – by providing training, learning and development opportunities to leaders and managers that meet identified organisational and service needs and /or individual development needs. We will do so by further developing the capability of colleagues across the Trust to design and deliver training, learning and development activities and by further developing relationships with specialist providers external to the organisation.

Technology-enabled Learning – by working with colleagues with specialist subject and technical knowledge to identify, design, procure and deliver learning activities using technologies. This includes e-learning, webinars, virtual communities of practice and learning and i-information via social and other media as an integral part of our corporate LMD programmes.

Coaching and Mentoring – by developing a network of coaches and mentors within the Trust to support our corporate LMD programme and talent management and succession planning activities. We will also develop a coaching and mentoring framework of specialists externally upon whom we can call to meet our requirements at need. This will be reflected in a *'Coaching and Mentoring Framework'*

Talent Management – by developing a framework and processes that allow leaders and managers to identify, develop and retain talent across our workforce. This will be supported via a programme of development opportunities and support, including Talent Pool; Development Centres; Coaching and Mentoring; Stretch Projects; Secondments; the corporate LMD programme; Learning Raids and Alliances

Succession Planning – by developing a framework and processes that allow Managers to undertake 'succession planning' for each key role within each of our leadership systems. This will be supported via the talent management arrangements and the corporate LMD programme.

Recruitment and Selection **-** by ensuring that the leadership behaviours that underpin our Values are an integral part of our current values-based recruitment processes.

A LMD Delivery Plan will be developed and will include detailed plans of the activities that support delivery of these priorities and the resources required to do so.

Our Provision of Development Opportunities:

We will develop a LMD 'Hub' to enable the provision of development opportunities to Leaders and Managers across the Trust. This will comprise a range of education, training, learning and development opportunities that meet the identified needs of Leaders and Managers (see Fig2). Equitable and fair access will be ensured in alignment and keeping with our *'Equality First'* strategy (see aligned document g) and *'Learning and Development Agreement'* (see aligned document k). Our approach to providing our Leaders and Managers with LMD opportunities will be needs-based to ensure that the ongoing development of both leadership and management practices occurs in the following ways:

- *Individually* - via continuing personal / professional development (CPD)
- *by Team / Service / Professional Group* - via targeted learning activities and service development
- *Corporately* - via Trust-wide development programmes and learning initiatives

LMD needs are identified through an annual review of Personal Development Plans (PDP) and which are agreed by both Staff Members and Line managers at Appraisal. The LandD Service reviews PDPs annually to identify common LMD needs upon which the corporate programme is based.

Professional LMD needs are identified by designated Medical, Clinical and other Professional Leads within the various professions across the Trust. Targeted LMD activities delivered to meet such needs will be co-ordinated either locally or in collaboration with the LandD Service to inform the corporate LMD programme.

Service-specific LMD needs are identified by designated Service Leads. LMD activities are co-ordinated either locally or shared with the LandD Service to inform the corporate LMD programme. This will be an integral part of our Trust-wide annual corporate business planning process.

Access to corporate LMD development opportunities is or will be provided in the following ways:

- a summary 'offer' to all Managers and including benchmarking against a *'Values-based Leadership and Management Competency Framework'* and details of the core and optional learning activities
- a needs-based programme of corporate LMD activities, reflected in the latter
- an annual brochure containing details of all corporate LMD activities
- a rolling calendar of all corporate LMD activities
- advice, guidance and support to Managers via LMD specialists within the LandD Service
- a register of LMD specialists external to the Trust and offering needs-based support
- a portal to information on corporate and other LMD activities on the L&D page of the intranet, creating a 'HUB'

Fig3

We will develop a LMD Delivery Plan to identify how the aforementioned development opportunities will be provided to Leaders and Manager during the period from June 2015 to March 2017. This will include the resources required to do, a schedule of development and provision and the impact criteria by which the success of our approach will be measured. Our intentions are listed in the Strategic Plan attached to this document (see Appendix b)

Our Alignments:

All corporate LMD activities are delivered under the provisions of the Trusts Strategic Plans and Operating Procedures. Also, these activities will be in alignment with and complementary to our Clinical, Nursing and Medical LMD intentions and needs. Furthermore, these activities will be in support of our transformation and innovation strategies, plans and programmes.

Our Impact and Success Measures:

In order to balance evaluating LMD activities and making effective use of limited LMD resources, evaluation of LMD is targeted at need. All corporate LMD and targeted programmes are evaluated across 4 x levels, as follows:

Level	Impact Measures	Coverage
1. Learners Reaction	Learners needs met	via Provider / L&D Dept.
2. Learning Outcome	Learning consolidated	via Provider / L&D Dept.
3. Applications to Work-role	Learning applied to regular working practices	via Service Manager / Trust performance reports
4. Impact on Service(s) and Trust	Impact on Service and Return on Investment	by sample via Service Manager / Trust performance reports

Fig 4

Impact and success measures will be developed for each LMD offer and aligned to our *'business'* and *'transformational change'* plans. These will also be linked to our seven 'Quality Priorities', the six 'C's of Nursing and the requirements of Monitor and the Care Quality Commissions for 'Well-led' Services.

Such impact measures may include identifying what the organisational benefits are of leadership activities such as:

- ❑ the impact of our Board and EMT in further developing our Macro System and influencing the Meta System;
- ❑ the impact of our Deputy Directors and TRIOs in further developing our Micro and Meso Systems;
- ❑ the impact of our Staff in further developing our Micro and Meso Systems;
- ❑ the impact of Leaders and Managers in meeting our intentions within our *'Health Improvement and Innovations'* strategy (see aligned document h) and our *'Transformation Programmes'*.

Progress will be monitoring against the priority activities listed within the *'LMD Strategic Plan'* (see Appendix b) on an ongoing basis by the Head of LMD.

Overall progress across the LMD activities within our LMD Delivery Plan will be reviewed monthly by the Deputy Director of HR and Workforce Development and Head of LMD and reported via the monthly HR Senior Managers Forum. The 'LMD Deliver Plan' will be used to monitor and reflect the progress made against the supporting activities for each agreed priority.

Our Reporting of LMD Activities:

Summary updates on the progress against each activity will be provided by the Head of Leadership and Management Development in the HR Strategic Objectives Plan (dashboard) and to the relevant Corporate, Directorate or Service forum at need.

Our Responsibilities and Accountability:

Responsibility for ensuring individual performance and capability and capacity of Leaders and Managers lies with the following:

- *Individually* – with each member of Staff in a managerial role and their respective Line Manager
- *Team / Service* - with the nominated Service Lead Manager
- *Directorate* – with the nominated Director and/or Deputy Director
- *Professionally* – with the Nursing / Clinical / Medical Director or Professional Lead Officer
- *Trust-wide* – with the Director of Human Resources and Workforce Development

Responsibility for ensuring the identification of corporate LMD needs and access to appropriate development of Leaders and Mangers lies with:

- *Director of Human Resources and Workforce Development:* accountable for the Head of LMD and the LandD Service; for ensuring corporate resource to support the delivery of our LMD Strategy and Delivery Plan; for assuring the Executive Management Team and Board.
- *Head of Leadership and Management Development:* for co-ordinating the implementation, monitoring and reporting of the Trusts LMD Strategy and associated Delivery Plans under authority of the Director of Human Resources and Workforce Development
- *Learning and Development Department:* co-ordinating the provision of corporate LMD programmes and learning activities.

Responsibility for the application of all supported LMD activities lies with the individual learner and their respective Line Manager

Additional Information:

Details of LMD and other provision is available via the intranet homepage of the LandD Department:
http://nww.swyt.nhs.uk/leadership-and-management-development/Pages/default.aspx

Appendices:

a) Definitions and Glossary of Terms
b) Strategic Plan

Key Documents to which this LMD Strategy is aligned:

c) 5-year Strategic Plan
d) 2014-16 Operational Plan
e) Quality Improvement Strategy
f) Nursing Strategy 2015/18
g) Equality First strategy
h) Health Improvement and Innovation Strategy – *in development*
i) 'How the Organisation Runs' – Parts 1 and 2
j) Learning and Development Strategy - *in development*
k) Learning and Development Agreement
l) Leadership and Management Development Strategic Delivery Plan - *in development*
m) Talent Management and Development Strategy and Succession Plan - *in development*
n) Agile Working Policy
o) Staff Engagement Strategy

Further Reading / Articles:

'Quality by Design – A Clinical Microsystems Approach' – E. Nelson, P. Batalden and M. Godfrey. Jossey-Bass (2007) ISBN:978-0-7879-7898-3

Clinical Microsystems research and development at Dartmouth College, New Hampshire, USA
https://clinicalmicrosystem.org/

Jönköping County Council, Sweden: *http://www.kingsfund.org.uk/time-to-think-differently/publications/reforming-nhs-within/case-study-1-j%C3%B6nk%C3%B6ping-county-council*

'Collective leadership for cultures of high quality health care' – M. West, et al.
Journal of Organizational Effectiveness: People and Performance Volume: 1 Issue: 3, 2014

'What Really Works…the 4 + 2 formula for sustained business success' – W. Joyce, et al.
HarperCollins (2004) ISBN: 0-06-051300-4
http://hbswk.hbs.edu/item/3578.html

Appendix A - Glossary of Terms:

Leadership is the deliberate use of influence through values-based behaviours

Leaders are any member of staff that consistently demonstrate leadership behaviours within their everyday working practices

Values-based Leadership is the alignment of the personal ethical values of staff members with the Trusts 'Mission and Values', resulting in measurable improvements in quality of care to Patients and Service Users

Collective Leadership is the deliberate, concerted and co-ordinated actions and behaviours of Leaders, resulting in measurable improvements in quality of care to Patients and Service Users

Clinical Leadership is the expert advice, guidance and involvement of clinical and Nursing specialists to ensure Patient safety and ensure best clinical practice and is defined in our *'Nursing'* Strategy

Medical Leadership is the expert advice, guidance and involvement of medical specialists to ensure Patient safety and ensure best medical practice

Diverse / Inclusive Leadership is defined within our Trust *'Equality First'* strategy. It includes developing a cultural workforce and ensuring access to LMD opportunities for under-represented groups in leadership and managerial roles, such as gender, ethnicity, and Professional Group.

Management is the efficient and effective co-ordination of available resources, including: Risk; Relationships; Finances; Environments; Equipment; Information; and Processes

Managers are members of staff whom have specific roles, responsibilities and are accountable for co-ordinating available resources to ensure our healthcare services are delivered

Management Systems are the 4 x environments within which Managers operate across the Trust, including:
Single Care Pathways and Services (Micro System); Multiple Care Pathways and Services (Meso System); Trust-wide and Strategic/Corporate Services (Macro System); External environments and relationships (Meta System)

Leadership and Management Development (LMD) is the formal and informal development of all leaders and managers employed by the Trust. This is achieved through the co-ordinated provision of education, training, learning and development activities. This approach ensures that we have well-led services through 'collaborative' leadership and leading to quality improvements across our portfolio of healthcare services.

Appendix B – Strategic Plan:

Period	Priority Actions / Outcomes		
	2015	**2016**	**2017**
Quarter 1	❑ Engagement of Leaders and Managers in 'Systems Leadership' and 'Values-based Leadership via EEMT, Deputy Directors and TRIOs	❑ Further embedding 'Systems Leadership' and 'Values-based Leadership via Microsystems development programme and Middleground 5 programme	❑ Further embedding 'Systems Leadership' and 'Values-based Leadership via needs-led LMD and Middleground 6 programmes
Quarter 2	❑ Widen engagement of Leaders and Managers in 'Systems Leadership' and 'Values-based Leadership' via Middleground 4 programme and B7 LNA workshops ❑ LMD Strategy developed and agreed ❑ Values into Behaviours draft Framework agreed	❑ Future LMD needs of Leaders and Managers scoped via annual business Planning (inc. Workforce and Succession planning), 360-feedback, and capability benchmarking; ❑ 'Values into Behaviours' embedded into Staff Appraisal ❑ 'Well-led' Microsystems benchmark-tested via MG5 and VLCs	❑ 'Well-led' Microsystems benchmark-tested via MG5 and VLCs ❑ Learning Alliance Framework developed and agreed
Quarter 3	❑ LMD Needs of Leaders and Managers scoped via Appraisal, 360-feedback, and capability benchmarking; ❑ LMD opportunities, support and programmes identified, planned and promoted via a LMD 'HUB' ❑ Coaching and Mentoring Framework agreed and tested	❑ LMD Needs of Leaders and Managers scoped via Appraisal, 360-feedback, and capability benchmarking ❑ LMD opportunities, support and programmes identified, planned and promoted via a LMD 'HUB' ❑ 'Well-led Service Transformation' case-examples developed and published	❑ LMD Needs of Leaders and Managers scoped via Appraisal, 360-feedback, and capability benchmarking ❑ LMD opportunities, support and programmes identified, planned and promoted via a LMD 'HUB'
Quarter 4	❑ Talent Management and Succession Planning Framework agreed and tested ❑ 'Values into Behaviours' agreed ❑ Virtual Learning Communities (VLCs) tested	❑ 'Systems Leaders in Health' Conference hosted ❑ 'Coach and Mentor Network' Conference hosted	❑ 'Systems Leaders in Health' Conference hosted ❑ 'Coach and Mentor Network' Conference hosted

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June2015
Agenda item 8.1(i)

Title:	**Calderdale and Kirklees Child and Adolescent Mental Health Services (CAMHS) – progress report**
Paper prepared by:	Director of Nursing, Medical Director and Interim Director of CAMHS
Purpose:	To provide an update on progress in the delivery of the recovery plan
Mission/values:	Improve and be outstanding in relation to the Recovery Plan Open, honest and transparent in terms of public reporting
Any background papers/ previously considered by:	Update reports previously provided to Trust Board, most recently 28th April 2015
Executive summary:	Following a successful tender bid, Calderdale and Kirklees CAMHS transferred to the Trust in April 2013. As the work to transform services commenced, the scale of the challenge became clearer and a recovery plan was developed in February 2014. This plan is ambitious and has shown progress, but Trust and Commissioners remained concerned that the scale and pace of change that was planned had not been achieved. Accordingly a series of 'Summit' meetings were held to oversee progress and service improvement. This paper provides a progress update against the actions agreed following the CAMHS Summits on 8 May and 19 June 2015 and the report to the Trust Board on 28 April 2015. The Clinical Governance and Clinical Safety Committee also received a detailed update on the Trust's portfolio of CAMHS in Barnsley, Calderdale and Kirklees, and Wakefield at its meeting on 16 June 2015. The investment in Calderdale and Kirklees CAMHS proposed by clinical commissioning groups is to be welcomed.
Recommendation:	**Trust Board is asked to NOTE the progress report**
Private session:	Not applicable

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Calderdale and Kirklees Child and Adolescent Mental Health Services (CAMHS)
Progress Report
Trust Board 30th June 2015

Introduction
The Trust took on the responsibility for the provision of Tier 3 CAMHS in Calderdale & Kirklees in April 2013, following a successful tender bid. Both commissioners and the Trust are clear that the scale of the challenge to remodel and transform the service was initially underestimated. A recovery plan was instigated in February 2014 and a substantial amount of work undertaken – and investment made – by the Trust to improve the service.

In January 2015, the Trust invested in additional management capacity to focus on CAMHS and also raised its concerns formally with Commissioners. This resulted in a CAMHS 'Summit' with the CCG CEOs and local authorities. The CAMHS Summit met originally on 20th March and subsequently in May and June, with further dates set for July and September 2015. The Chairman of the Trust attended the meeting on 8th May 2015.

Formal Trust monitoring takes place through the Trust's Clinical Governance and Clinical Safety Committee, which received a detailed report on the position in April and June 2015.

The Trust Board receives regular updates on CAMHS in Calderdale & Kirklees, most recently in January, March and April 2015. This report provides an update on progress.

National Context
Nationally, the profile of CAMHS has been raised with the establishment of a Task Force in September 2014 and its subsequent report 'Future in Mind'. In addition there were statements in the Chancellor's autumn statement in December 2014 and the Budget in March 2015, announcing additional funding to transform mental health services for children and young people.

In order to access these additional funds, Commissioners need to develop a Transformation Plan by the end of September 2015. Key elements of the plans will be creating Eating Disorder teams and improving crisis and self-harm services, as well as Commissioners working collaboratively to transform and improve services. It is clear that the improvement in access and waiting times for CAMHS services are going to remain a significant national priority.

CAMHS Summit

The CAMHS Summit met on 8th May and 19th June to oversee the joint programme of work and to monitor progress. The meeting on 19th June confirmed:

- The Trust was on track with its Data Quality plan and able to report that the backlog of referrals for the generic CAMHS service had now been cleared, with the earliest referral now waiting being May 2014. Although these still remain very long waiting times for young people and their families, 50% of young people are waiting less than six months for an intervention following their initial appointment. The increased investment in crisis services should release capacity to focus on reducing these waiting lists.

- There are still long waits for a multi-agency assessment for Autistic Spectrum Disorder (ASD). Commissioners are aware of the situation and looking at ways to improve the ASD position, whilst acknowledging that SWYPFT provides only a part of the solution to a robust multi-agency pathway for those families seeking an assessment for ASD.

- The CCGs agreed that there was significant underinvestment in the CAMHS service in Calderdale & Kirklees and this needed to be remedied. In the initial phase, the crisis intervention/intensive home based treatment team would be funded. The funding would come from Calderdale & Kirklees Commissioners 0.4% Parity of Esteem monies, coupled with the 1% demographic growth monies, which the CCG would invest in early intervention, as identifying and treating children appropriately will have a long term effect on their adult mental health.

  The 'Task and Finish' group would continue to meet to make recommendations for further investment to ensure that the service was able to meet the outcomes of the specification when it was revised. Commissioners are currently considering extending SWYPFT's contract for a further year, in order to embed the improvements and develop a specification that met the CCG's requirements and incorporated the requirements of the national NHS England CAMHS Specification.

- As part of the jointly agreed programme of 'Enhanced Surveillance', a detailed Quality Dashboard has been agreed. In addition, Commissioner visits had been undertaken on 29th May and 10th June 2015. Positive feedback – from both Commissioners and the Trust - was given and all agreed that these had been beneficial. Further visits will be arranged, particularly from Kirklees Commissioners.

- A report on the Governance arrangements is in draft and will come to the July meeting. The CCGs are starting to prepare their Transformation Plans, with the Lead Commissioner in Calderdale being Calderdale Council and the CCG in Kirklees. The plans are due for completion by the end of September 2015 and will require engagement with stakeholders and young people and will also have to go through an assurance process.

- The Joint Communication strategy was noted and agreed to be refreshed as necessary. The need for proactive, rather than reactive communications was reiterated.

SWYPFT Governance

A detailed report on the performance of the Trust's CAMHS services in Wakefield, Barnsley and Calderdale & Kirklees was presented to the Clinical Governance and Safety Committee on 16th June 2015. Future reports to the Committee will include a dashboard of metrics presenting the whole of the Trust's portfolio of CAMHS services, encompassing both Barnsley and Wakefield, in order that performance and improvement can be demonstrated.

Two Non-Executive Directors, the Chair of the Clinical Governance & Clinical Safety Committee and Chair of the Mental Health Act Committee visited the CAMHS service in Calderdale & Kirklees on 12th May and spoke to staff and managers. A further Non-Executive visit is planned to Barnsley services.

Locally, CAMHS remains a high profile issue and reports on CAMHS services were received by the Kirklees Health & Well Being Board on 28th May and presented to the Calderdale Scrutiny Committee on 24th June 2015.

The CQC has been kept fully informed of the issues faced in Calderdale & Kirklees CAMHS, most recently at the CQC Relationship meeting on 20th May 2015.

Service Development

The additional investment from the CCGs is to be welcomed as is their clear commitment to improving CAMHS services for children and young people in Calderdale and Kirklees.

Pending the formal confirmation of funding, the Trust had already commenced the recruitment of additional crisis team staff, in order to manage the operational risks of providing both emergency and planned care. Commissioners, whilst acknowledging the low levels of investment, are keen that any additional investment is not permanently tied to any definite element of service provision. Commissioners would ideally wish to commission a service based on outcomes, rather than particular service elements, and the need for flexibility has been acknowledged by the Trust.

The need to ensure that CAMHS services in Barnsley now receives intensive management focus and support has been identified. These services transferred to the Trust from Barnsley MBC in April 2013 and – as with many CAMHS services – need to work with commissioners to improve waiting times, redesign pathways of care and operationally manage both planned and emergency work, whilst facing increasing demand. Formal reporting on the services in Barnsley is now through the Clinical Governance and Clinical Safety Committee which received a detailed report on all three services in June 2015.

21st June 2015
Tim Breedon, Director of Nursing, Clinical governance & Safety
Nette Carder, Interim BDU Director - CAMHS
Adrian Berry, Medical Director

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 8.1(ii)

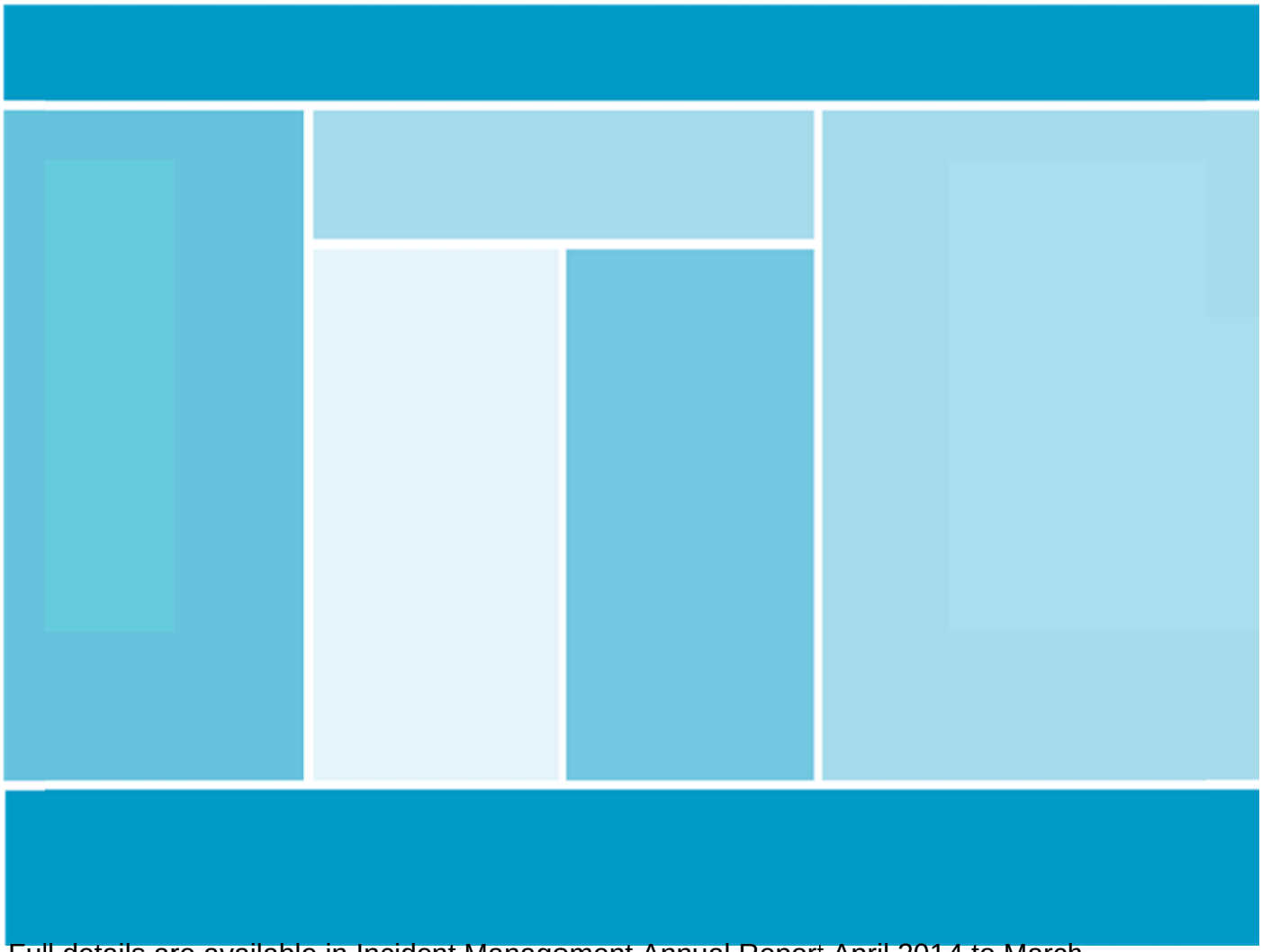
Title:	**Incident Management Annual Report 2014/15**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. The full report and this summary report have been reviewed in detail by the Clinical Governance and Clinical Safety Committee, and this review has further informed the work plan for incident management reporting during 2015/16.
Executive summary:	This report provides an overview of **all** incidents reported by the Trust during 2014/15, a summary of serious incidents and of the themes from recommendations of completed serious incident reports that have been sent to the Commissioners between April 2014 and March 2015. The report, plus further breakdown of information at BDU level will be circulated to BDUs. Although the CGCS will receive assurance on the action required, and further interpretation of the data, at this stage Trust Board can be advised of the following. ➢ Incident reporting levels are higher than last year with over 1,000 additional incidents being reported. An organisation with a culture of high reporting is positive. The distribution of these incidents in terms of severity is pyramid-shaped, serious incidents being fewest in number, with most incidents (84.7%) resulting in no/low harm. ➢ There were no 'Never Events' reported in 2014/15. ➢ There were no homicides reported during 2014/15. ➢ There were 106 serious incidents reported during 2014/15. ➢ There were 34 pressure ulcers reported. Of these, 29 were grade 3 and five grade 4. Following further investigation six pressure ulcers were seen as avoidable. ➢ In 2014/15, 56 deaths were reported 45 of which were suspected suicides and eleven unexpected deaths. Suspected suicides have increased on previous years (2013/14 = 23, 2012/13 =31 and 2011/12 = 28). Trust Board is asked to note that the data is the category at the time of reporting from information the Trust is aware of and not the verdict by the Coroner, which is what is used in the National Confidential Enquiry. ➢ Analysis of suspected suicides using population size and National Confidential Enquiry data shows that a Trust of this size would expect to see between 31 to 36 potential deaths by suicide. The four-year average is 31. ➢ The Trust will not be able to compare national data for this year until July 2017

	when that data is published. ➢ There was a spike serious incidents in May 2014 and this was reviewed but there were no themes found in terms of services or teams, or of themes. Similarly, a thematic review of seven suicides in Barnsley did not find any trends or themes to suggest systemic care or service delivery problems. **Next steps** Recent years have seen substantial developments in the framework, personnel and processes supporting the investigation, management and learning from incidents in the Trust. This provides a secure platform from which to develop further, particularly with an emphasis on learning. Plans for 2015/16 include the follow. ➢ In response to elevation in suicide risk nationally and locally, and as part of the Trust's Patient Safety Strategy, the Trust is developing an overarching suicide prevention strategy. It will complement suicide prevention strategies of local authorities, which are tasked nationally with taking a lead on suicide prevention. It will be based on elements of the National Suicide Prevention Strategy and incorporate important recommendations from other bodies, such as the National Confidential Enquiry into Suicides and Homicides by People with Mental Illness (NCISH). ➢ Further analysis of suicides will be conducted as part of the Trust's annual undetermined deaths audit, which will be monitored through the Clinical Reference Group and reviewed by the Clinical Governance and Clinical Safety Committee. ➢ Implementation of Patient Safety Strategy including national *Sign up to Safety* initiative, ensuring the duty of candour is embedded and Safewards. ➢ Continued development of practice governance posts for each service line (or individuals in similar roles) to ensure learning closer to frontline staff and provide greater opportunities to capture the impact of learning. ➢ Developing ways of capturing the impact of lessons learned and action plans implemented. ➢ Greater support in investigating lower level incidents. ➢ Continue to support incident management research. ➢ Examining how front line managers can be added to dashboard reports enabling them to use real time incident data following a successful business case. ➢ Implement Datix upgrade and exploit the features available to support safety.
Recommendation:	**Trust Board is asked to RECEIVE the report.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Summary Review of Incident Management Annual Report 2014/15



Full details are available in Incident Management Annual Report April 2014 to March 2015

1. Introduction

This report provides a summary of the detailed incident management annual report April 2014 to March 2015. The report will present headline data, brief analysis and some of the key next steps planned for 2015/16.

In recent years the Trust has ensured that all services and teams acquired have been added to Datix (incident management recording tool) and have access to reports and training made available by the Patient Safety Support Team. The team have worked with both internal and external partners to ensure the Trust has a robust system to enable reporting, investigation and analysis of incidents. This report need to be reviewed with the undetermined death audit (once available) that provides detailed information matching data collected by the National Confidential Inquiry.

2. External scrutiny and feedback

A number of questions are asked within the **national staff survey 2014** which provided direct feedback on staff views with regards to the incident reporting system. The 2014 staff survey published in 2015 reported that the Trust was better than average for Mental Health Trusts in the percentage witnessing potentially harmful errors, near misses or incidents in last month. National figure was 26% and Trust figure was 23%. It also reported that the Trust was similar to other Trusts for the percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice.

One area that requires further examination with the Business Delivery Units (BDUs) is the percentage of staff reporting errors, near misses or incidents witnessed in the last month. The survey highlighted that only 88% of staff had reported incidents, this is 4% below the national average. The report does show this improved within the Trust from the previous year by 1% and some team responses were so low that the data could not be included.

The Patient Safety Support Team has produced video guidance to support staff in reporting incidents along with a wider variety of short training sessions. Locally we have seen over 1000 additional incident reports this year.

Datix was able to provide all of the information required for the quality account following a piece of work to enable the Trust to report the same data as the National Patient Safety Agency in relation to degree of harm arising out incidents.

An improvement target of 5% was set from the time an incident was reported to being reviewed by managers. The patient safety support team communicated with managers and set up additional monitoring tools to support this. The target was met. This was again externally audited.

Under Department of Health guidance HSG (94) 27, an independent investigation must be undertaken when a homicide has been committed by a person in receipt of specialist mental health services under the Care Programme Approach in the six months prior to the event. Such investigations are to provide “an external verification and quality assurance review of the internal investigation with limited further investigation”.

This year the Trust has been involved with 3 independent investigations. The investigations commissioned through NHS England are an independent review of 3 homicide cases that took place in the Trust between July 2010 and June 2011. One of these has already been subject to a domestic homicide review which was reviewed as adequate by the Home Office. A fourth report will also cover the implementation of learning from 3 earlier incidents which took place between March 2007 and December 2008. The reports have been received and an action plan has been developed which is being reviewed through the clinical governance and clinical safety committee and with the clinical commissioning groups through the quality board. Good progress is being made against the action plan.

3. Headline data

The Trust reported 10990 incidents of all severity during the year, over a 1000 additional incidents compared to previous year. The range within a quarter is 2666-2854 incidents. The distribution of these incidents in terms of severity is pyramid-shaped, serious incidents being fewest in number, with most incidents (84.7%) resulting in no/low harm.

Serious incidents are defined by NHS England and include suspected suicide of service users, homicide by service users, never events, serious assaults and confidentiality breaches as well as attempted suicide (life threat/serious injury), and the unexpected death of an inpatient.

106 (72 excluding pressure ulcers) serious incidents were reported to the commissioning CCGs via the Department of Health database, STEIS/Unify.

34 pressure ulcers were reported. 29 were grade 3, and 5 grade 4. Following further investigation 6 pressure ulcers were seen as avoidable.

There were no homicides reported in 2014/15.

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. No 'never event' incidents were reported by SWYPFT in 2014/15.

3.1. External comparison

There are limited opportunities to compare the Trust data. The National Reporting and Learning Service produce six-monthly reports comparing mental health trusts. There are limitations with this data, in that SWYPFT is compared with Trusts providing only mental health services, whereas the Trust also provides community services and has a large forensic component. Subject to this caveat, the latest report for April–September 2014 shows the Trust in the middle 50% of reporters, with a reporting pattern for numbers of incidents in particular categories similar to other Trusts. The Trust was also part of a national benchmark in relation to restraint and overall the figures for the Trust were positive.

3.2. Internal comparison

The patient safety support team has undertaken analysis of serious incidents by category, team, month and year within the full report. There are no obvious trends by teams or category from previous years.

In 2014/15 there were 72 serious incidents (not including pressure ulcers) in comparison to 56 the previous year.

Chart 4 shows the number per 100,000 population of all serious incidents reported by the Trust. 4.44 -6.78 dependent on the BDU.

Chart 1-SI by type 2014/15

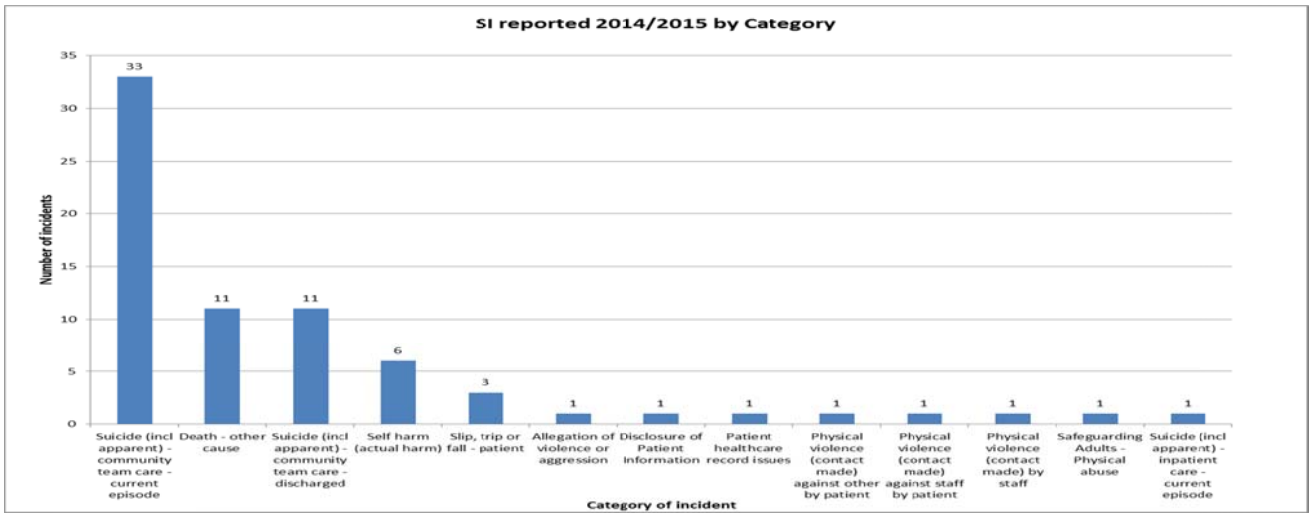
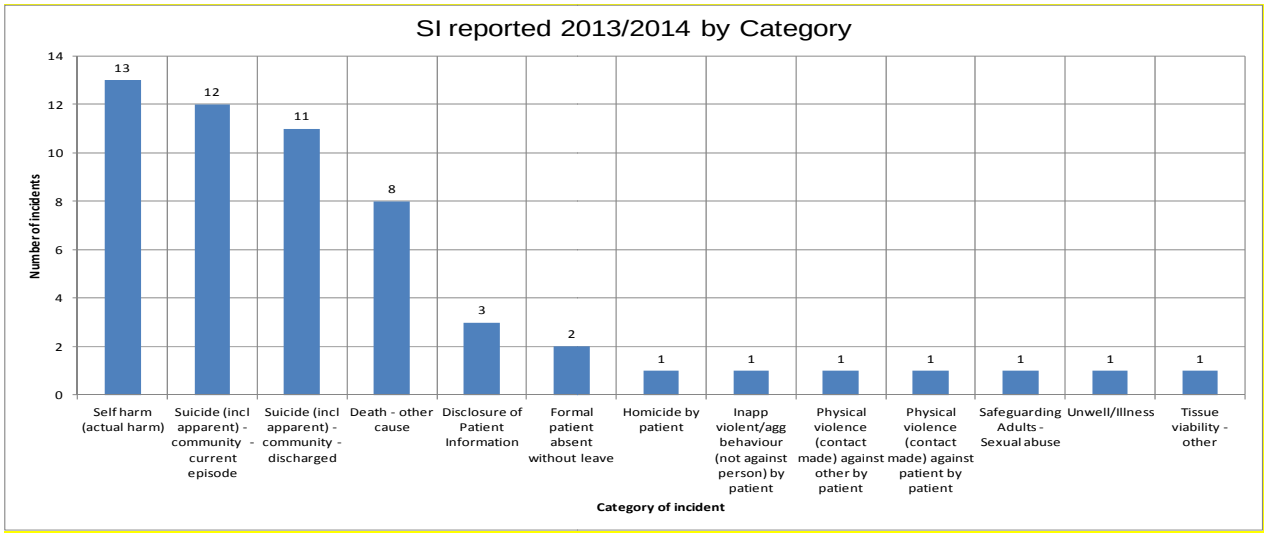


Chart 2- SI by type in 2013/14



i) Suspected and actual suicide

The largest single category at the time of reporting the incident was suspected suicide**,** with 45. This is higher than previous years (2011/12=28, 2012/13=31, 2013/14 =23 (22 as 1 due to natural causes). The reporting criteria are incidents which include current patients or someone who has been discharged within the last 12 months. These criteria have been the same for the last two years.

The Trust will not know for a few years if this increase is in line with a national picture, as National Confidential Inquiry is based on data two years behind and the latest information covered 2012. It is of note that there is likely to be an increase in suicide nationally and locally due to prevailing socio-economic factors (Coroners statistics, 2011; NCI, 2014).

The increase has been across BDUs and not in any particular team. This type of SI was most frequent in working aged adult services, and most suicides were by service users in contact with community services or discharged from services. This is consistent with national findings (NCI data). The main method of suicide is hanging, which again is in line with the national data.

Chart 3 2014/15 - Suspected suicides broken down by BDU and method indicated at time of reporting.

	Barnsley MH&SMS	Calderdale	Kirklees	Wakefield	Total
Hanging - self injury	8	4	5	6	23
Contact with moving vehicle (car, train) - self injury	0	0	2	1	3
Method unknown - self injury	0	1	1	1	3
Over the counter medication - self poisoning	1	1	1	0	3
Illicit drug - self poisoning	0	1	0	1	2
Jumping from height	0	1	1	0	2
Other - self poisoning	0	0	2	0	2
Other self-injury	1	0	1	0	2
Carbon monoxide - self poisoning	0	0	1	0	1
Cutting - self injury	0	0	1	0	1
Drowning - self injury	1	0	0	0	1
Prescription medication - self poisoning	0	0	0	1	1
Suffocation - self injury	0	0	1	0	1
Total	11	8	16	10	45

Using population size and national confidential inquiry data only, based on SWYPFT geographical area and population would expect between 31-36 patient deaths by suicide per year. The annual report breaks this down by BDU and type and shows the previous year for comparison. The suspected suicides over the last four years average out at 31 per year.

Chart 4

District	Population ONS – population estimates Mid 2013	General population suicide rate (NCI)	Patient suicide rate (28% general pop) (NCI)	Suspected suicide reported on STEIS 2013/14	Suspected suicide reported on STEIS 2014/15	All SI Incident figures per 100,000 population for 2013/14	All SI Incident figures per 100,000 population for 2014/15
Barnsley	235,757	22-25	6-7	5	11	5.17	6.36
Calderdale	206,355	19-22	5-6	7	8	4.4	6.78
Kirklees	428,279	40-45	11-13	9	16	3.07	4.44
Wakefield	329,708	30-35	8-10	2	10	4.29	5.76
Trustwide	1,200,099	111-128	31-36	23	45		

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

Again this information must be viewed with caution, because the Trust does not have access to the local actual general population data. The table shows the reported expected incidence of suicide in SWYPFT by BDU based on BDU populations and the NCI data. These NCI figures do not reflect socio-economic or other factors that might influence suicide rates and are simply averages of the data collected. NCI 'patient' data includes all cases where the coroner gave a verdict of suicide or an open verdict for any person who had been in current contact with mental

health services or in contact in the preceding 12 months. The numbers for each BDU with the exception of Wakefield are above the number expected and higher overall.

Further analysis of 56 deaths this includes suspected suicide and unexpected deaths at point of reporting on STEIS/Unify

Current service user	45
Discharged service user	11

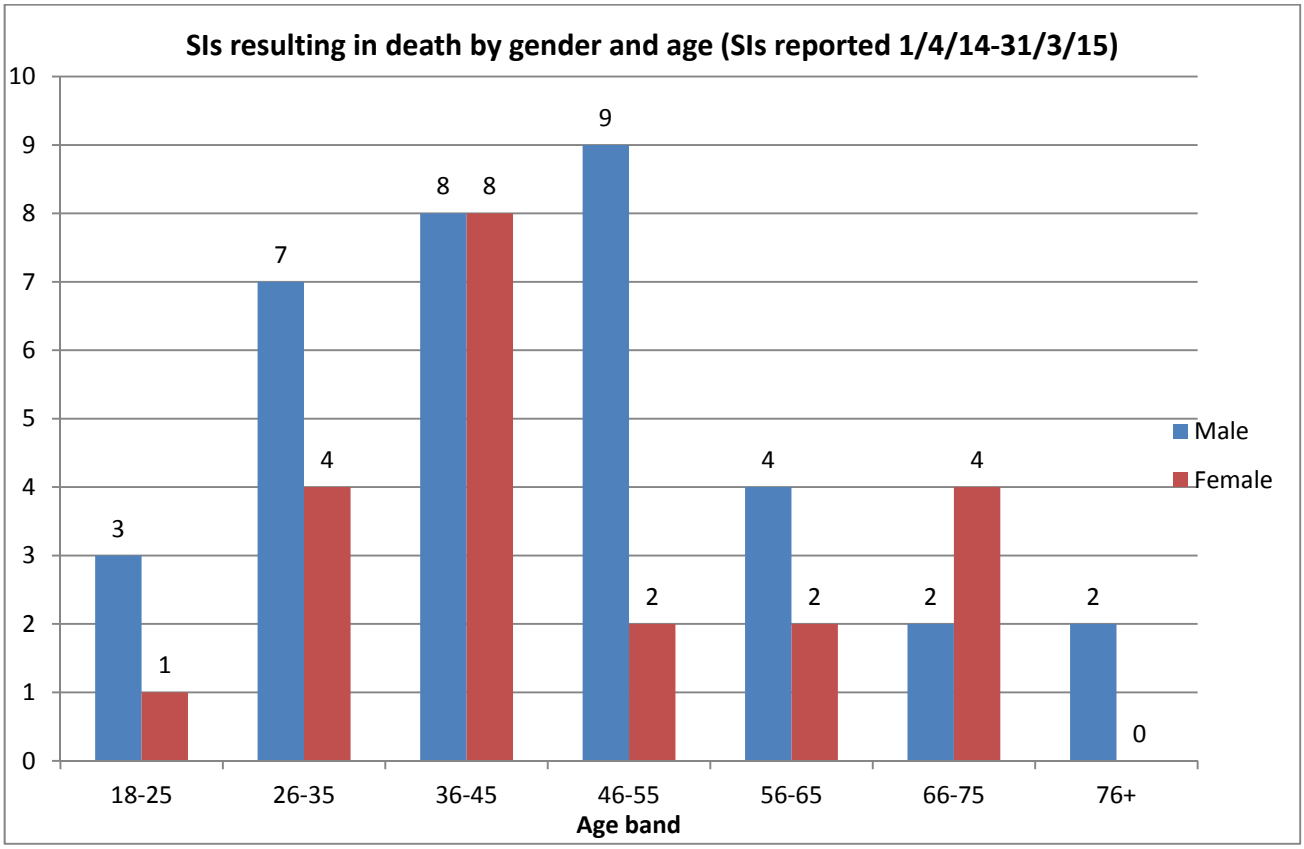
Care programme approach

CPA	19
Standard Care	21
N/A	11
Not recorded	5

Detained under the mental health act

Detained under MHA	1

Note -a further 2 serious incidents involved detained patients; these are coded to slips, trips and falls. The new serious incident framework now captures whether the person is subject to mental health act or other healthcare related restrictions so reporting on this will be easier in future years.



This chart shows the gender and age distribution of all serious incidents relating to death. Overall, of the 56 deaths, there were 35 male deaths and 21 female deaths. Based on the National Confidential Inquiry data from July 2014, we would expect 25 deaths by suicide for males and seven for females (data up to 2011), a total of 32. It is of note that not all 56 deaths in the chart above are suicides or suspected suicides. It is likely that a maximum of 45 reported

The National Confidential Inquiry July 2014 also showed number of suicides in male and female patients aged 25-34 fell in the report period. There was an increase in the number of male suicides in those aged 45-54, 55-64 and 65+. The Trust highest figure for males is in the age group 46-55 but almost as high was the 36-45 age range.

Service users not in contact with services at time of death

Days	Number
0-30	4
31-60	2
61-90	1
91-120	1
121-150	2
151-180	0
181-210	1
Data missing	1

For the past two years the Trust has reported deaths of individuals who are current service users or discharged patients up to twelve months were we are informed. The Trust has developed good relationships with Coroners officers to support this reporting.

Thematic review of deaths in Quarter 1

In Q1 2014/15 there were 20 SIs (excluding pressure ulcers), a higher than expected number based on the pattern observed in previous years and in Q4 of 2013/14 (from 2010/11 to 2013/14 there were 14, 12, 15 and 14 SIs in Q1 respectively).

In Q1 2014/15 these comprised 12 suspected (including apparent) suicides, five deaths due to causes unknown, one incident of serious violence against staff, and two of self-harm.

One of the deaths of unknown cause occurred in December 2013 but was included in Q1 2014/15 due to new information coming to light about the cause of death in that quarter.

The data relating to these deaths and incidents was reviewed to determine whether there was a particular trend, in terms of mode of death/harm or identifying any service that had a higher proportion of deaths of service users under their care.

Data reviewed included Datix reports, which gave an indication of the mode of death (although not a detailed account since there had been no detailed investigation at that stage) and tables relating to the services in which the incident occurred.

The 12 apparent suicides were spread fairly evenly across teams in the Trust. Of these, 11 were in current contact with services. 5 (42%) were by hanging (one self-harm SI was by hanging also). This proportion is roughly in line with nationally published figures for patient suicides. 1 apparent suicide was by contact with a train, 3 by self-poisoning and 1 by cutting. The deaths of other cause were also spread evenly across services.

Three services had more than one SI in the quarter reviewed. Of these three, CMHT Lower Valley Calderdale had 2 suicides, CMHT Care Management Team Kirklees one suicide and one death of unknown cause, and Pontefract CMHT four had one suicide and one death other cause.

On the basis of these data and the small numbers involved, there did not appear to be an unexpected pattern or trend to either the mode of death or the service in which the incident occurred.

Barnsley thematic review of suicides

The Trust conducted a thematic review of seven cases of suicide reported in Barnsley between July 2014 and December 2014. When undertaking a review of the care and delivery issues, the investigation team examine the information that is available at that time and whether the decisions followed policy and guidance and whether these need to change.

All but one of the individuals was in the community at the time of the incident; four had been discharged from the service at the time. The services do not know what had occurred from the time of discharge to the time of death. None were re-referred to services.

The investigators identified the need to review clinical risk training in three of the incidents and other recommendations were linked to risk factors –communication on the ward, handover of risk in previous 24 hours and risk assessment form needing reviewing.

One case is an IAPT case where the assessment is much briefer as this is high volume, low risk referrals and the service was trying to engage with the individual at the time of the incident. The investigators did have a view that the referral should have been sent to alcohol services or CMHT, this may have occurred following assessment. None of the incidents were seen as preventable but the investigation provided time to review and reflect on opportunities to improve practice in the future. Action has been taken in relation to these recommendations.

The Trust is reviewing the risk assessments being used and a Trust wide piece of work is taking place in relation to risk training. In the short term the immediate review highlighted the need to more time to be spent on risk formulation and this has already been actioned. The BDU review the incident recommendations at least twice a year to examine themes from recommendations. These recommendations also feed into Trust wide analysis of themes.

In conclusion, there were no obvious trends emerging from the review of the seven cases, although lessons have been learned from the reviews and are being implemented to improve practice.

ii) Homicides

There has been 0 homicide reported in 2014/15.

iii) Death– other causes

11 incidents were reported in this category an increase from the previous two years which both recorded 8 incidents. This has included patients that the cause of death is unclear or accidental e.g. a client recovered from a river by police, a suspected morphine overdose which was being used for pain management. It can take a significant amount of time for the cause of death to be clear but this does not prevent the investigation being completed. The cause of death may not be a patient safety issue and be natural causes, of the 11 reported incidents:-

3 - Cause of death was found to be cardiac related deaths
2- Found to be overdoses but not known if accidental or deliberate
2 -Still unknown to the Trust
1-Narrative
1- Accidental
1 –Suicide
1 –Found in car with probable self-harm.

iv) Self-harm/attempted suicide

During 2014/15 there were 6 serious self-harm incidents, this is a significant reduction from the previous year when 13 were reported. In 2012/13 there were 3 incidents. The incidents included cutting –self injury (2), self-poisoning (2), jumping from a height (1) and hanging (1)

v) Information governance

Information Governance incidents which have a score of 2 or above on the Department of Health table are graded as red and managed as a Serious Incident (SIRI) by the Trust.

vi) Pressure ulcers

During 2013/14 the requirement to report grade 3 and 4 pressure ulcer incidents as Serious Incidents was introduced (**May 2013).** As anticipated, the reporting requirement for pressure ulcers changed in early 2015. The revised criteria to report only avoidable pressure ulcers came into effect in in February 2015.

Prior to February 2015
The Trust reported all incidents that were attributable whether or not they were avoidable.

From February 2015
The Trust reports incidents that are attributable and avoidable. This is confirmed at a monthly meeting against standard good practice criteria. 34 pressure ulcers were reported (29 grade 3 and 5 grade 4); following investigation 6 were found to be avoidable.

The Tissue Viability action plan for 2014-15 was completed on time except for purchase of Repose mattresses as business case submitted to the CCG was unsuccessful. Reducing the frequency and severity of harm resulting from pressure ulcers has been identified as one of the five priorities for the Trust's Sign up to Safety Improvement Plan for 2015-2018.

3.3. Duty of candour

Duty of candour became a statutory requirement in November 2014 for health providers. The patient safety support team had already undertaken work and been reporting to Clinical Commissioning Groups from April 2014. Duty of candour is applicable to all incidents that result in moderate harm or above.

132 incidents were applicable 2014/15. The Trust is undertaking an audit against the requirements of duty of candour in 2015/16.

4. Performance feedback as of 15.5.15

During the period 1 April 2014 to 31 March 2015, 111 serious incident investigation reports were submitted to the relevant commissioners (please note this is not the same data as those reported in this period).

Feedback to date has been received on 105 of these investigations.

60 reports were submitted to Barnsley CCG, which does not formally grade the quality of the investigations. Barnsley CCG provides narrative feedback that the investigation will be closed on STEIS or request additional information. Feedback on two investigations is awaited.

Of the remaining 51 Serious Incident investigations submitted to other commissioners, feedback has been received on 47 investigations. Feedback is awaited on 4 investigations. Two of these investigations were ungraded. Of the remaining 45 investigation reports, they all received a feedback rating. 96% (43) (note - same figures as last year) resulted in a quality rating of good or excellent. 2% (1) resulted in a fair rating. 2% (1) resulted in a weak rating. The weak grading was due to the action plan not being submitted in time not the quality of the investigation report. Further clarification was provided to the commissioners on 28 investigations.

5. Governance structure

Reporting, analysis and learning from incidents is managed through a clear governance structure. The Director of Nursing, Compliance and Governance works closely with the Medical Director to ensure there are robust processes in place. This is supported by an Assistant Director for patient safety and an Associate Medical Director (AMD) for patient safety. The patient safety support team provides support to all BDUs and Quality Academy teams. Investigation of serious incidents is undertaken by full-time lead investigators, supported by dedicated medical investigators. A list of co-opted experts within the Trust has been developed from a variety of specialties and disciplines to provide specialist support to SI investigators where necessary.

The Clinical Governance and Clinical Safety Committee ensure robust scrutiny on behalf of the Board. The Committee receives performance information.

Bi-monthly patient safety clinical reference group meetings are now established. Chaired by the AMD for patient safety, it is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety. There is a particular emphasis on investigations, recommendations and action plans arising from serious incidents and on how learning is disseminated both locally and trust-wide.

Each BDU has developed governance groups whose function includes examining trends and learning from incidents and ensuring action plans are delivered. Each BDU facilitates local learning events for frontline staff, led by practice governance coaches.

The Patient Safety Support Team also supports research and development proposals relevant to incident management. This year a member of the team has undertaken research on the effectiveness of the investigation process, the results will be shared in July 2015.

6. Findings from investigations

A majority of the recommendations from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator is working with the BDUs in producing a report on learning from recommendations. A total of 176 recommendations were made from the reports submitted, these were all related to care and delivery but not seen as a direct cause of the incident. There were 16 reports that had no care and delivery issues and therefore no recommendations. This is a positive sign that services are learning from incidents and ensuring care delivery is safe and of a high standard despite the outcome.

In 2014-15 the most frequent three recommendation types were:

Staff education, training and supervision — is the most frequent recommendation however during the year we noted that district nursing service had a repeated recommendation of sharing the learning so during the year another code of sharing learning was added to separate this recommendation. It accounted for 19 recommendations. This section covered a wide level of training requirements, some of which are on the mandatory training list for others training has been arranged or review of current training is taking place. This year highlighted

the need to ensure Doctors were clear about the training they need to attend and how Doctors in training are clear about key Trust practices around Care Programme Approach and did not attend policies.

Organisational systems, management issues — issues arose around clear implementation plans for polices and procedural changes in a number of incidents. Work had to take place on the emergency bag equipment for CPR following a discrepancy that came to light during an investigation. Staff do not always escalate issue to senior staff or use the risk register to record these. The clinical recording system –RiO has had some recommendations in relation to use. Need to be clear were next of kin is recorded and monitor this, a number of issue have arisen about contacting families after serious incidents as this has not been recorded. Some records have been cut and paste and not updated.

Record keeping — this has been in the top three recommendations for the last four years. Most recommendations have been in relation to accuracy of record and clear recording of clinical decisions. As recorded in the organisation issues above there were recommendations about not recording next of kin in this category also. Not always validating records or recording the reason for cancellation of record. There needs to be clear recording of medication in medical care plans and on discharge.

Last year a piece of work was undertaken in ensuring timely monitoring and implementation of action plans. The position at the end of this year is significantly improved.

7. Learning lessons and Safety Culture

All care providers must put patient safety at the forefront of the delivery of healthcare. The Francis report, and the government response, *Hard Truths*, among others have highlighted the need for trusts to develop a proactive and positive safety culture and robust systems and processes to monitor safety and implement change on the basis of lessons learned. The Trust has engaged with a number of opportunities initiatives towards fulfilling this aim, including the new Patient Safety Collaborative and the *Sign up to Safety* initiative. The completion of an overarching Trust patient safety strategy has provided a framework to support such initiatives.

Each BDU now has a practice governance coach (or personnel with a similar role) to assist in the dissemination of learning arising from SIs. Every SI investigation is followed by a learning event for the individual team or service involved. In addition, BDUs have held wider learning events for staff to highlight themes and trends from incidents (both serious and otherwise) along with lessons learned. The workshops have been attended by a broad cross-section of staff and have been well evaluated. However, the Trust still needs to develop further its processes for measuring the subsequent impact of these action plans and learning events by capturing evidence of positive change, whether that be in terms of the quality of care provided, a measurable change in safety culture or a reduction in the frequency or severity of incidents.

8. Next steps

Recent years have seen substantial developments in the framework, personnel and processes supporting the investigation, management and learning from incidents in the Trust. This provides a secure platform from which to develop further, particularly with an emphasis on learning.

Plans for 2015-16 include:

- **Suicide Prevention Strategy**: In response to elevation in suicide risk nationally and locally, and as part of the Trusts Patient Safety Strategy, the Trust is developing an overarching suicide prevention strategy. It will complement suicide prevention strategies of local authorities, which are tasked nationally with taking a lead on suicide prevention. It will be based on elements of the National Suicide Prevention Strategy and

incorporate important recommendations from other bodies, such as the National Confidential Enquiry into Suicides and Homicides by People with Mental Illness (NCISH).

One strand of the strategy will include addressing the needs of individual service users, ensuring that when present, risk is recognised and responded to, both in terms of clinical treatment and support, but also helping to tackle other contributory factors, such as housing, financial and legal problems. This will necessarily be underpinned by ensuring that staff are appropriately trained and that the right resources and clinical pathways exist to provide this care. Clinical risk training for staff is also being reviewed across the Trust to support the suicide prevention strategy

Another strand will involve addressing the needs of the population and stakeholders with whom the Trust has contact more generally, and will include promotion of engagement with mental health services and strengthening links with partner agencies which have a role in the prevention of suicide to develop a holistic approach to suicide prevention. A further element, linked to the Trust patient safety strategy, will be to track self-harm, suicides or suspected to try and identify trends or themes, from which the Trust can learn and implement change to reduce future risk where possible.

- Further analysis of suicides will be conducted as part of the Trust annual undetermined deaths audit, which will be monitored via the Clinical Reference Group and reviewed by the CGSC.
- Implementation of patient safety strategy including:-
    - national *Sign up to Safety* initiative
    - ensure duty of candour is embedded
    - Safewards
- Continued development of practice governance posts for each service line (or individuals in similar roles) to ensure learning closer to frontline staff and provide greater opportunities to capture the impact of learning.
- Developing ways of capturing the impact of lessons learned and action plans implemented.
- Greater support in investigating lower level incidents.
- Continue to support research.
- Examining how front line managers can be added to dashboard reports enabling them to use real time incident data following a successful business case.
- Implement Datix upgrade and exploit the features available to support safety

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 8.1(iii)

Title:	**Customer Services annual report for the financial year 2014/15**
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 2014/15 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: • 265 formal complaints were investigated, with learning shared as appropriate • 237 informal concerns, 714 enquiries and 162 comments were made • 824 compliments were corporately recorded and shared • 226 requests for information under Freedom of Information Act were processed (an increase on the previous year of 206). Customer Services activity increased in the year, 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 2014/15 and to NOTE this in the broader context of ongoing work in relation to understanding service user experience.**
Private session:	Not applicable

TRUST BOARD – 30 JUNE 2015

CUSTOMER SERVICES - ANNUAL REPORT FOR THE FINANCIAL YEAR 1 APRIL 2014 TO 31 MARCH 2015

INTRODUCTION

This report provides an overview of feedback received by the organisation through the Customer services function in the financial year 2014/15.

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.

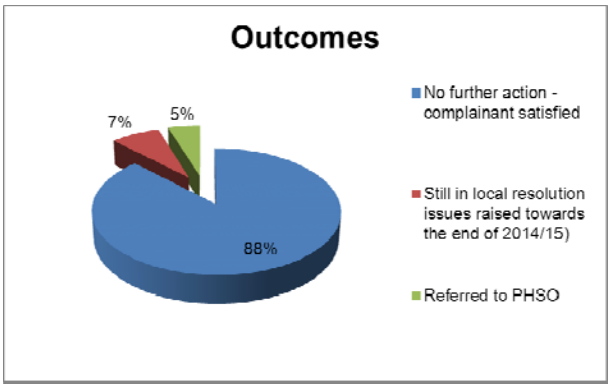
This report includes:

- 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

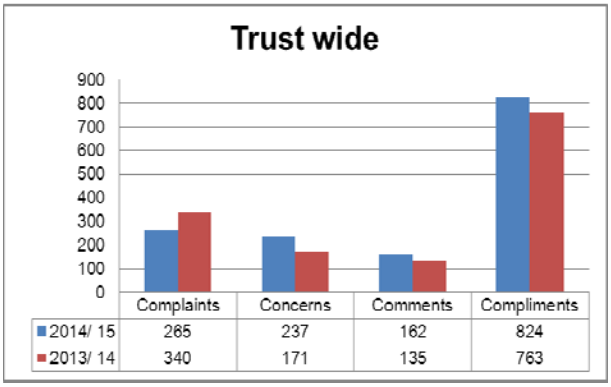
FEEDBACK RECEIVED

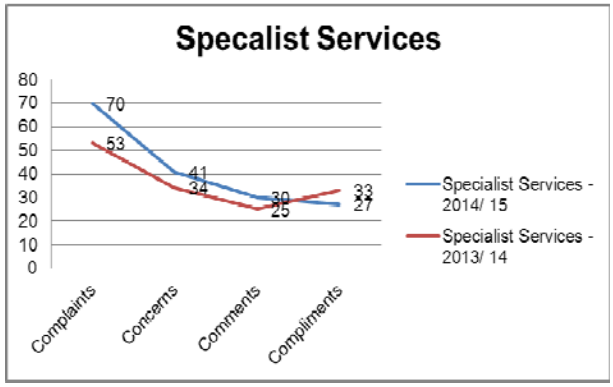
The table below illustrates Customer Services activity in 2014/15. The number of formal complaints received in the year was 265; this reflects a decrease on the last two years, when 340 and 289 complaints were recorded respectively. There was an increase in the year in the number of issues resolved at service level.

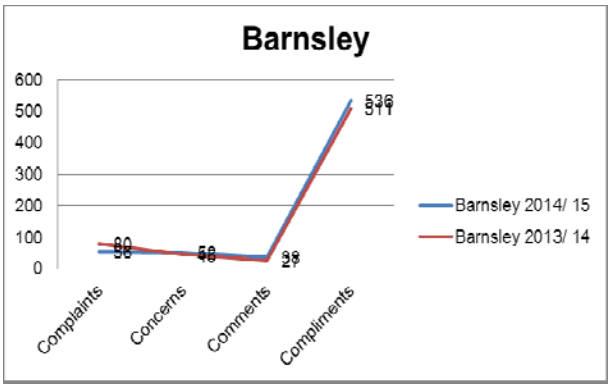
FORMAL COMPLAINTS PROGRESSION

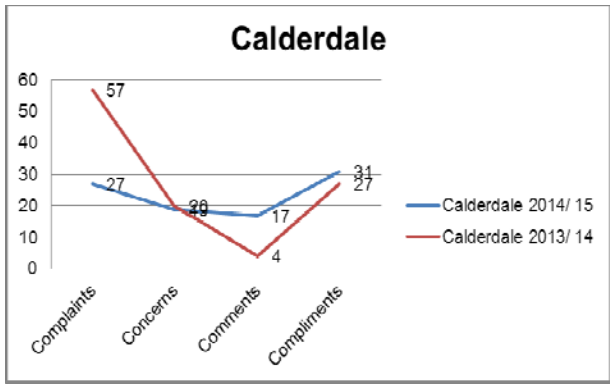


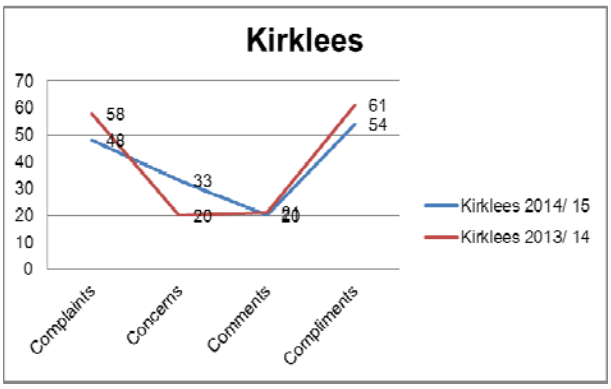
CUSTOMER SERVICES ACTIVITY 2014/15

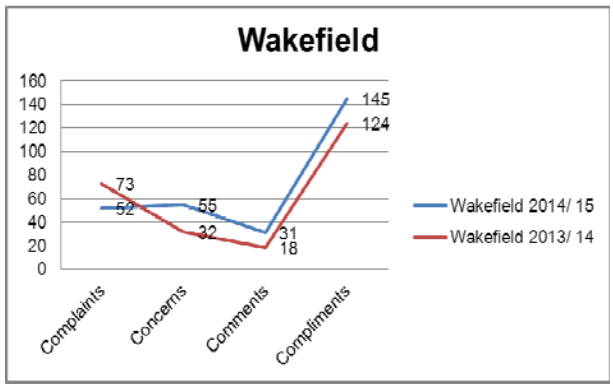


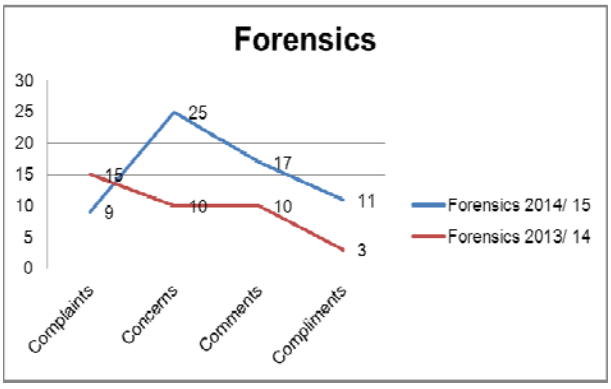


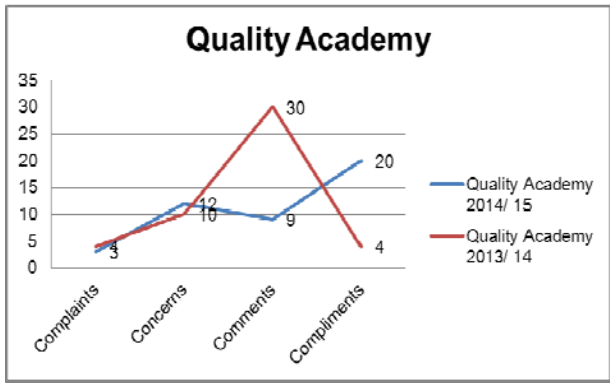












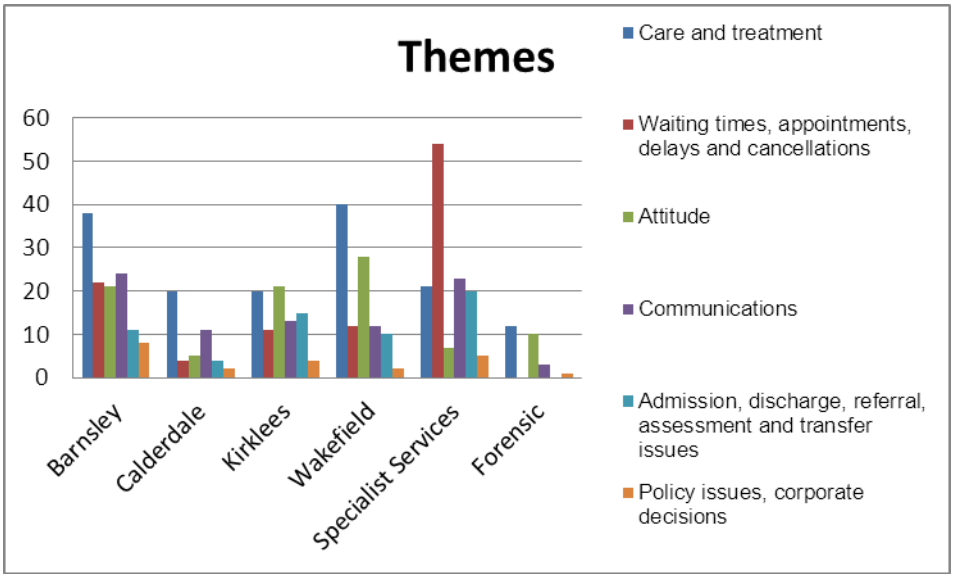
NUMBER OF ISSUES RAISED INFORMALLY

During the year, Trust services responded to 399 issues of concern and comments at local level compared to 306 the previous year. 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 (151). This was followed by waiting times (103), with waiting times for assessment by the CAMHS service (shown under specialist services in the chart below) being the most common issue. There were 92 complaints about staff attitude, 86 about communication, 60 about admissions, discharge and transfer issues and 22 about policy and corporate decisions. Most complaints contained a number of themes. BDUs develop action plans to address issues through governance processes and utilise Quality Academy support, for example, the 'right first time' training offer and individual service review.

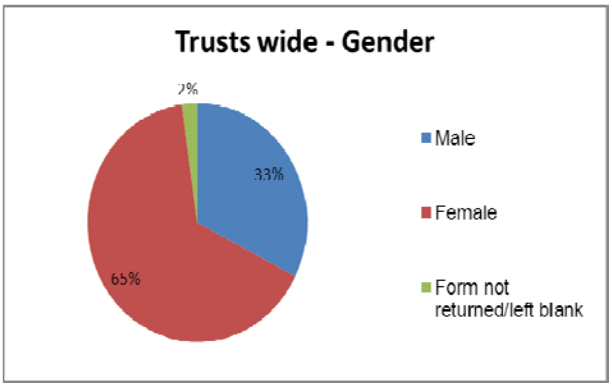
The Customer Services function connects to risk scanning which brings together intelligence from the Patients Safety Support Team and the Legal Service Team to triangulate any issues of concern and assess the impact on service quality. Issues subject to serious incident review are flagged to ensure appropriate support at the right time should any related issues become subject to complaint.



EQUALITY 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 53%. The charts that follow show where information was provided, the breakdown in respect of gender, age, disability, sexual orientation and ethnicity. The total number of complaints received and information provided across the characteristics is shown in each table.

Work is ongoing with other NHS organisations in customer service and complaints networks to benchmark performance in collecting equality data to ensure best practice is employed in Trust processes.



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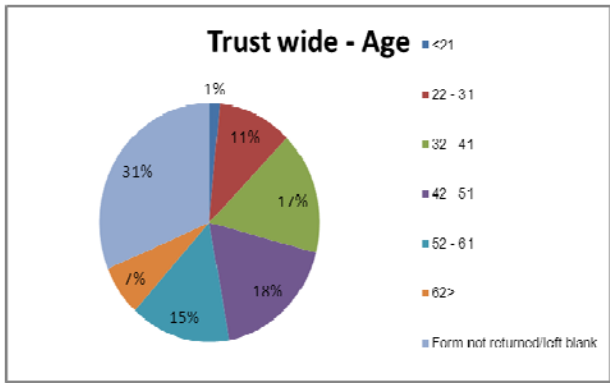

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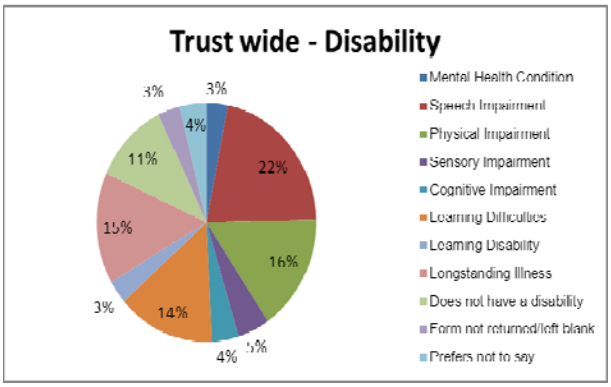

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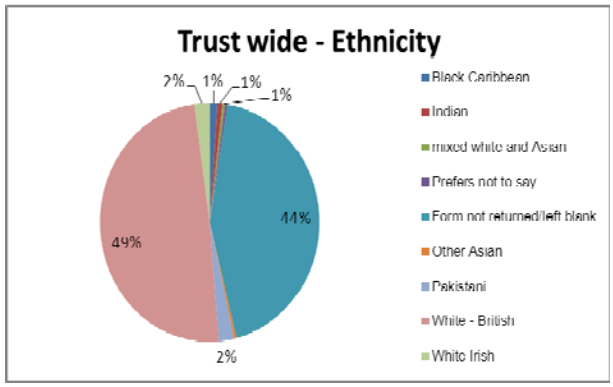

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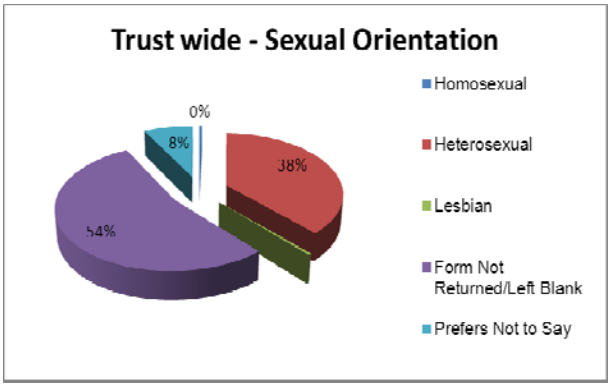

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MP CONTACT

During 2014/15, there were 50 occasions where complaints and feedback were received via local MPs acting on behalf of constituents. Enquiries received are processed in line with routine practice and contact made direct with individuals wherever possible.

Barnsley BDU: Dan Jarvis MP (4)

4 separate issues raised relating to – corporate decision, record keeping and lack of support.

Calderdale BDU: Linda Riordan MP (2), Jason McCartney MP (1)
3 enquiries received relating to – waiting times, perceived lack of support and access.

Forensic BDU: Patrick McLoughlin MP (1)
1 issue raised regarding – policy and procedures.

Kirklees BDU: Simon Reevell MP (1), Jason McCartney MP (4), Barry Sheerman MP (1), Mike Wood MP (1)
7 enquires relating to – lack of communication from CMHT, policies and procedures regarding out of areas transfers, waiting times for assessment for CMHT and perceived lack of support from CMHT.

Specialist Services BDU: Ed Balls MP (2), Jason McCartney MP (4), Jon Trickett (3), Simon Reevell MP (3), Yvette Cooper (3), Mike Wood MP (2), Barry Sheerman MP (1), Dan Jarvis MP (1), Ed Miliband MP (1), Craig Whittaker MP (1)
21 enquiries received - All contacts received were in relation to CAMHS. 16 concerns raised were in relation to waiting times for assessment, 3 were in relation to the perceived lack of support service users were receiving and 2 were in relation to access issues.

Trust wide – Dan Jarvis (1), Angela Smith MP (1)
2 separate issues raised relating to – Trust assets, and policy and procedures relating to communication resources.

Wakefield BDU – Yvette Cooper (6), Mary Creagh MP (3), Jon Trickett MP (3)
12 enquiries raised regarding - trust policy and procedures in relation to service user disclosure, attitude of staff, access and perceived lack of care from CMHT, record keeping, waiting times for psychological therapies, medication issues and detention under MHA,

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

At the start of the financial year, 1 case was still waiting consideration by the PHSO (Kirklees). During the 2014/15, 13 complainants (3 Wakefield, 3 Kirklees, 1 Calderdale, 2 Speciality Services, 2 Forensics, 1 Trust wide 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:

- 8 cases were closed by the Ombudsman with no further action
- 1 case was resolved by recommended actions to current processes, and 1 case through financial redress in sum recommended by the Ombudsman
- 4 cases were awaiting a decision at the end of the financial year.

MENTAL HEALTH ACT

8 complaints were made in the year with regard to service user detention under the Mental Health Act.

2 of these were raised by people describing themselves as white British 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 2014/15 the CQC referred three complainants to the Trust who had approached them directly.

One complaint related to Specialist Services, CAMHS in relation to waiting times and the quality of the service.

Two complaints related to Wakefield inpatient services, regarding the care and treatment of a service user and lack of support offered to a bereaved family.

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.

I would acknowledge again the contribution of the customer services officer. The detail that she provided was very helpful. We will now be closing the case.
Allan Brown, Mental Health Act Reviewer. CQC

Customer services team have given their time and expertise in assisting us with our re-development of PALS and Complaints. This has included sharing templates and policies/procedures.
Patient Advice and Complaints Team Bradford District Care Trust

The Customer Service Team continuously works in partnership with other organisations, agencies and the public to improve complaints processes thus ensuring that those raising concerns are highly valued and fully supported throughout. ***Leeds Teaching Hospitals NHS Trust***

I have been in post for around 5 years and throughout my time in this role; the Customer Services team has provided invaluable advice and support to me. The team are always open to assisting me when I make contact and I can always trust that I will get a helpful response to my enquiries. ***Kirklees LA***

I don't have any hesitation in encouraging the people I work with to contact customer services for help and advice during the course of a complaint or if they have other issues regarding their care under the Trust.
ICAS Advocate

The Customer Services team are a friendly bunch of folk who demonstrate their person first approach by always promptly willing to help and support me with handling and investigating complaints regarding services provided by SWYPFT. This helps to ensure we provide complaint responses to clients which are honest, open and transparent which in turn assists to resolve the complainant's concerns and prevents their complaint going any further.
Calderdale, Greater Huddersfield and North Kirklees Clinical Commissioning Groups.

The Customer Service function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. During 2014/15, in addition to routine requests, feedback was provided in relation to a national study regarding issues affecting deaf and hard of hearing people.

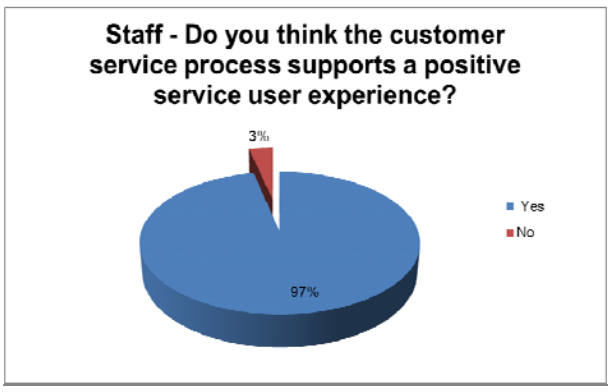
Issues spanning more than one organisation	Complaints	Concerns	Comments	Total
Barnsley Hospital NHS Foundation Trust	5	0	1	6
Barnsley Metropolitan Borough Council	3	0	0	3
Care Quality Commission	0	1	2	3
Kirklees Council	1	1	0	2
NHS Barnsley CCG	0	0	1	1
NHS Bassetlaw CCG	1	0	0	1
NHS Calderdale CCG	2	0	2	4
NHS Greater Huddersfield CCG	1	0	2	3
NHS North Kirklees CCG	1	0	1	2
NHS Wakefield CCG	2	0	0	2
Other Local Authority	3	1	0	4
Wakefield Metropolitan District Council	3	0	0	3
Total	22	3	9	34

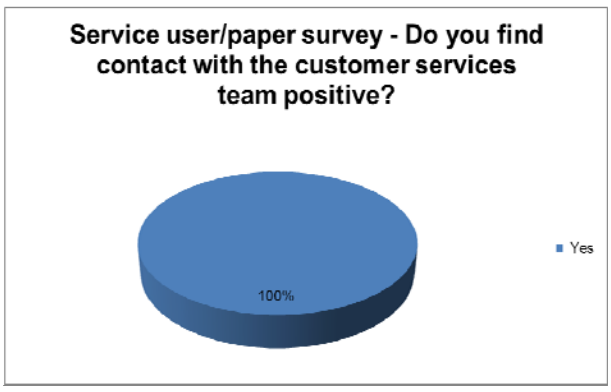
CONTACT WITH THE CUSTOMER SERVICES TEAM

The customer services team processed 714 general enquiries in 2014/15 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 groups. The team also responded to over 1325 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 a telephone survey – meeting expectations to support real time feedback and improve responsiveness, the results of which will be included in future reporting.





29 staff offered feedback and 68 service users.

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.

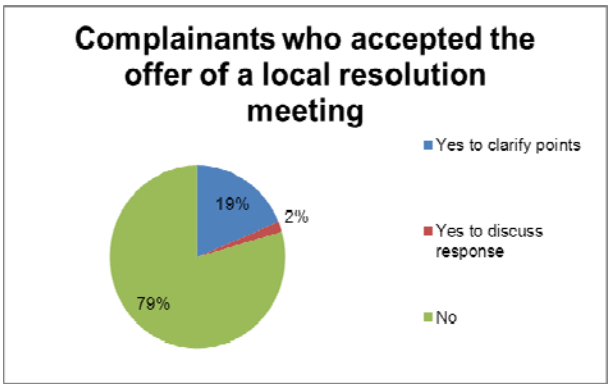
These meetings are ideally attended by both Customer Services and service staff and provide an opportunity for staff to reflect on the experience from the service user's perspective. A small number of service user/carers took up the offer to meet. All complainants are also offered a meeting when they are advised the outcome of an investigation, to discuss any outstanding concerns they may have.

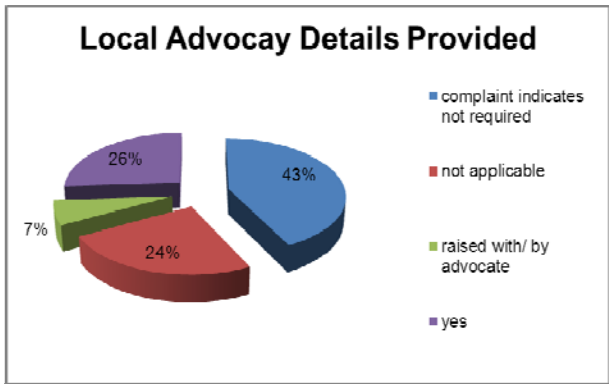
Feedback from staff shows that meeting with complainants improves overall understanding of how people who use services and their families are affected by contact with services.

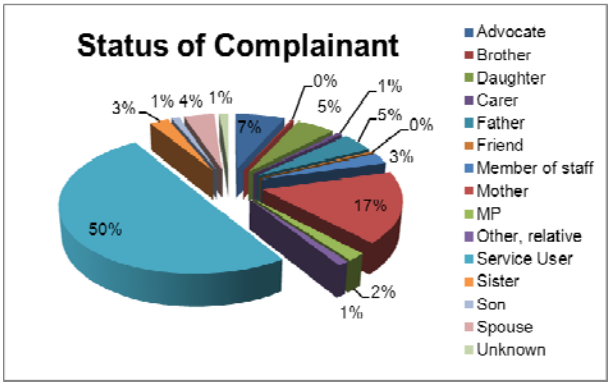
> The team supports services to be the best that they can by ensuring comments and complaints are actioned and addressed. I believe the team has gone over and above by visiting the BDU and gaining a real understanding of the service we provide.
> ***Forensics***

> I find the service to be helpful in setting out the concerns and supporting me to meet or respond to individuals raising concerns in a way that improves the service and patient experience
> ***Wakefield OPS***

All complainants are informed that independent advocacy services are available to them in their area, and are encouraged to use this support if helpful. A small number of service users are supported by an advocate. Customer services monitor the take up of support.







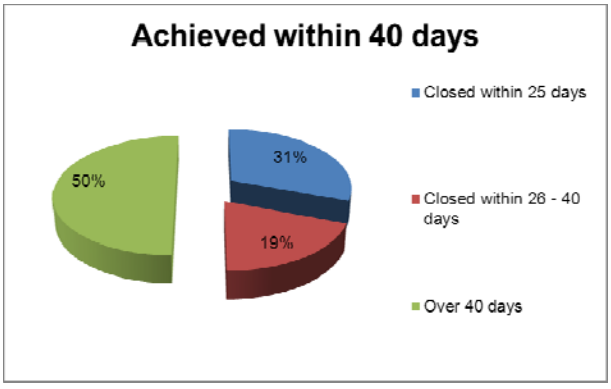
Complainants may wish to communicate in writing (by letter or completion of the Customer services feedback form), over the phone, by email, via the website or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is an essential 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.

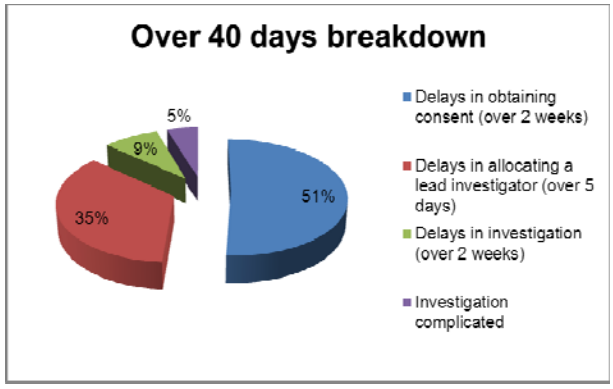
RESPONDING IN A TIMELY MANNER

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 internal target is for every complaint to be responded to within 25 days; or 40 days for the most complex cases.

In 2014/15 the Customer Services team closed 294 complaints. 31% were closed within 25 days and a further 19% within 40 days. Of the remainder, delays in obtaining consent and delays in allocating an investigator at BDU level were factors. Deputy directors and general managers are kept updated on progress in complaints investigation and Customer Services work with individual services to support identification of investigators and to support dedicated time for investigation jointly with services.

Complainants are kept up to date on progress with their complaint through weekly contact with the allocated case worker.





COMPLIMENTS

During the year 824 compliments were recorded, an increase on 763 received in the previous year. Compliments 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 promote good practice.

Your laid back, friendly but informative approach has really helped me and I could not have done it without that support.

Barnsley – Health Improvement

A big thank you for all your help and support you have given me. You have taught me how to look at things differently. I will forever be in your debt.

Calderdale – Psychological Therapies

I was treated with respect, kindness and reassurance. Wonderful work done by the mental health team.

Kirklees -CMHT North

I would like to thank all the staff and doctors. The doctors made me feel well in a matter days I have been off medication about three years and doing really good.

Forensics – Bronte Ward

Specialist Services

Thank you for all your help it really means a lot
Specialist Services - CAMHS

Thank you for putting up with me whilst I have been in your care. You have showed such compassion. Your endless patience is quite remarkable. Cheers for everything.

Wakefield – 136 Trinity Suite

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.

All complainants received a detailed response to the issues raised and an apology where appropriate. Over 129 actions were taken and changes implemented in response to feedback

These include:

Barnsley BDU

- A community service has introduced a process to ensure family/carers have access to repeat prescriptions from GP's whilst service users are in inpatients settings ***(mental health services - CMHT WAA)***
- An IAPT service is reviewing the process to ensure that service users on the waiting list are kept updated ***(mental health services – psychological services)***

- A health visiting team is reviewing the protocol for information sharing with other parties, for example, GP's. Auditing of recorded documentation has also been introduced. (***Primary care and Preventative services and Long Term conditions)***
- Staff on an inpatient ward have been reminded to provide service users with a copy of their care plan and ensure this action has been documented in healthcare records***(Inpatients)***
- IAPT staff ensure they explain the types of therapy and methods offered and discuss these with service users to minimise any confusion regarding the service offer. ***(mental health services – psychological services)***
- District nursing staff seek clarification of service user understanding regarding procedures, and follow up on concerns as and when they arise ***(Long Term conditions)***
- Further training and support relating to catheter procedures is to be offered in a district nursing team. ***(Long Term conditions)***
- Staff from the health visiting team have reviewed the issues around professionalism in relaying sensitive information to carers. (***Primary care and Preventative services)***
- Staff have being reminded of the importance of adhering to the confidentiality policy when discussing information with family members ***(Inpatients)***
- Additional training regarding moving and handling have been put in place ***(Primary care and Preventative services)***
- Staff have being reminded of the importance of involving and updating service users in regards to decisions made in respect of care and treatment and also to involve families and carers where possible. ***(Inpatients, and mental health services - CMHT WAA)***
- Monitoring of administrative tasks is underway to ensure they are carried out in a timely manner. (***Children's business unit)***
- Information and contact details are to be provided for advice regarding self-management issues ***(long term conditions services)***
- the importance of updating and reviewing individual's records in a timely manner has been reiterated to staff ***(long term conditions services)***
- Review of the current process and systems to be undertaken to prevent future administrative errors to ensure clients receive good customer service. ***(primary care and preventative services and long term conditions services)***

Calderdale & Kirklees BDUs

- Crisis service staff have been reminded about the importance of using clear communication with service users/carers and families, and to ensure that the information provided has been understood.
- Details regarding discharge and the discharge policy to be provided to service users in writing, in addition to discussion ***(Acute Inpatients – WAA)***
- Staff from a Kirklees service are to ensure that the carer and/or family involved in assisting the recovery of a service user are also offered assessment of their needs.
- CMHT in Kirklees are reviewing the process for patients transferring into the area to ensure all relevant information has been provided.
- Additional training is to be provided to team mangers regarding 'Deprivation of Liberty'***(Acute Inpatients –OPS)***
- Processes are being put in place to ensure correct information is provided to carers, relatives and service users regarding ward rounds, CPA's and Tribunals. ***(Acute Inpatients – WAA)***
- Staff are to inform managers of any major/significant changes to a person's care package***(Acute Inpatients – WAA)***
- A family's experience of receiving care has been shared with the crisis assessment team as a learning exercise, and the importance of appropriate and professional conduct when making contact with service users and families has been reiterated. ***(acute –Crisis/IHBT)***
- Attention has been given to more accurate recording and onward communication of telephone messages in a Calderdale CMHT. ***(Community Services – WAA)***

- Sample caseload screening is underway in the Insight team to ensure copies of care plan documentation are routinely provided to service users in line with Trust policy. ***(Community Services – WAA)***
- Revised procedures are in place in a Kirklees CMHT to ensure consent is received in advance from service users where requests are made for students to attend home visits along with practitioners. ***(Community Services – WAA)***
- The Kirklees Insight team will ensure the reason for appointment cancellations is always recorded. ***(Community Services – WAA)***
- Outpatient services in Kirklees will attempt to contact service users when clinics are running late to make people aware of the delay and to offer the choice of re-scheduling.
- Staff have being reminded of the importance of involving and updating service users in regards to decisions made in respect of care and treatment and also to involve families and carers where possible. ***(Inpatients – OPS)***
- Additional processes have been implemented to ensure support is provided to patients in the community. ***(Community Services – WAA)***
- Clear processes have being implemented between services to reduce referral delays. ***(Community services WAA)***
- the importance of involving and listening to families and carers during ward rounds has been reiterated to staff members ***(Acute Inpatients – WAA)***
- Staff have been reminded of the importance of carefully explaining medication issues during discharge planning meetings, and also who should be in attendance at discharge meetings. ***(Acute inpatients – WAA)***
- the importance of involving and listening to families and carers regarding aspects of care planning has been reiterated to staff members ***(inpatients OPS) & (acute services - inpatients WAA***
- Staff have being reminded of the importance of being mindful of their surroundings when discussing sensitive information with patients and/or families and carers. ***(Acute Inpatients – WAA and rehab and recovery services)***
- reception staff at a CMHT are to receive additional customer services training ***(community services WAA)***
- Improvements to administrative processes to ensure clients receive information in a timely manner ***(acute services - inpatients WAA)***
- Staff have being reminded of the importance of involving service users in regards to decisions made in respect of care and treatment ***(rehab and recovery service)***

Wakefield BDU

- Inpatient ward housekeeping staff and catering staff are reviewing the process to ensure that correct meals are delivered on a daily basis, with improved communication between the two functions. ***(Acute inpatients – WAA and Trust wide services)***
- Duty workers have been reminded of the importance of returning telephone calls in a timely manner ***(community services WAA)***
- New processes have been introduced to ensure better coordination and communication between CMHT's and crisis services. ***(community services WAA & acute services)***
- 136 suite staff have been reminded about the value and importance of involving and listening to carers and family members during the assessment processes. ***(Acute inpatients – WAA)***
- Wakefield memory clinic staff will ensure in future that the side effects of medication are always discussed with service users and with carers and that information leaflets are always provided. ***(community services OPS)***
- APT practitioners have reviewed the safeguarding process, clinical and management supervision in respect of same, and the need to maintain familiarity with multi-agency safeguarding procedures. ***(community services – psychological services)***
- Staff attitude and the need to remain polite and professional at all times have been discussed with reception staff in a Wakefield CMHT.
- Staff from an inpatient ward have been reminded of the importance of sharing care plans. ***(Acute inpatients – WAA)***

- Staff have been reminded of the policies in place regarding the right to appeal under the Mental Health Act. ***(Inpatient services OPS)***
- Staff on an inpatient ward have received additional training and have been reminded of the importance of ensuring medication records are updated and that communication between staff and patients/carers has also been reviewed ***(Acute inpatients – WAA)***
- Staff on an inpatient ward are to receive additional customer services training and additional supervision ***(Inpatient services OPS***
- A full review of communication pathways and care standards is currently under review ***(Inpatient services OPS)***
- Staff are to ensure that clear explanations are provided for recording specific information and information regarding access to records is available to patients ***(acute services WAA)***
- A review of current transfer pathways between PICU and acute inpatient wards to be undertaken and communication between staff and service users/carers has also been reviewed ***(acute services – inpatients WAA)***
- Staff are to ensure that carers/families viewpoints are incorporated within service user care plans ***(community services WAA)***
- Staff on an inpatient ward are to receive additional customer services training and additional supervision ***(inpatients – OPS)***
- Trust staff have been reminded to always ensure appropriate letter-headed stationary is used in responding to service user issues ***(OPS)***

Specialist services BDU

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

- The way assessments are conducted has been subject to review and practitioners will ensure format appropriate to individual and that service users / families are given the opportunity to ask questions / express concerns.
- The need to accurately document all communications with families and/carers and to follow up on agreed actions as speedily as possible.
- The importance of clearly communicating the rationale behind the decision to discharge
- Staff have being reminded of the importance of involving and updating service users in regards to decisions made following assessment/appointments in respect of care and treatment and also to involve families and carers where possible.
- Additional processes have been implemented to ensure record keeping errors are kept to a minimum
- Staff have been reminded of the importance of returning calls in a timely manner
- The Trust is in the process of reviewing current IG processes, in relation to issues around consent and the releasing of healthcare records
- The Trust continues to work closely with commissioners in respect of the improving access and wait times for service users and exploring the need for a crisis services to meet emergency need.

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

- The service has put a process in place to ensure that when key workers are absent from work, family members are regularly updated regarding the impact on services.
- A revised system has been implemented to ensure all correspondence/telephone contacts are recorded and responded to in a timely manner
- A review of the current multi–agency ASD pathway has been commissioned to improve waiting times
- Improvements to administrative processes to ensure clients receive good customer service.

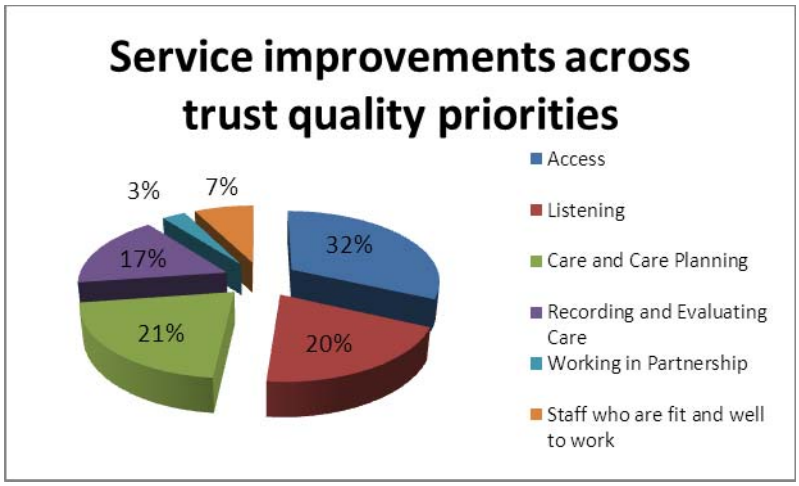
- Staff to provide opportunities for parents/carers to feedback their views separately following clinical meetings.

Forensics BDU

- The importance of explaining restraint and seclusion procedures to service users has been reiterated to ward staff.

The forensic team are building on recent positive feedback on involvement, including the One Voice Group, the unit-wide Carer's Dialogue Group and recent ward based family events. A ward manager led work to raise awareness of the importance of recording positive feedback from service users, to share good practice and to have this acknowledged through Trust processes. The Customer Services monitoring form has been shared with all wards and staff are being encouraged to capture all feedback. Progress in this area will be monitored and included in future reporting.

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



EXAMPLES OF SERVICE USER AND CARER EXPERIENCE

Harrison – raised concerns on a number of occasions about the standard of food offered in an inpatient unit.

Catering/housekeeping and ward staff implemented a new process to ensure that any concerns were raised with catering staff immediately. A comments and compliments book was introduced and service users and staff were encouraged to contribute. A new form has also been introduced that service users can complete and return in the internal post to catering. Ward meetings also now include catering issues, for example menu choices and the quality of food as a standing agenda item.

Jonathan raised concerns regarding the care and treatment his father, Eric, received whilst he was cared for on an inpatient ward. Jonathan explained that it felt like there was no communication between the family and staff members, and that they had been excluded from ward rounds and received no information regarding medication issues.

In response to the concerns raised, the General Manager and a Customer Services representative met with Jonathan to discuss his concerns and review his father's care. The General Manager has used feedback from this case to review procedures on the ward and as learning for staff in ensuring improved communication and a customer service focus.

Lynsey was referred to the Improving Access to Psychological Therapies (IAPT) team. She attended two face to face appointments with a therapist, but following these sessions, was only offered telephone support, with no explanation as to why the service offered to her had changed.

This complaint highlighted the issue that the IAPT process and likely progression was not always fully explained to service users, which resulted in confusion and a feeling of being moved on to a less helpful service. Team procedures were reviewed to ensure that the service offer, including the possibility of telephone based support is always discussed at the outset to manage expectations.

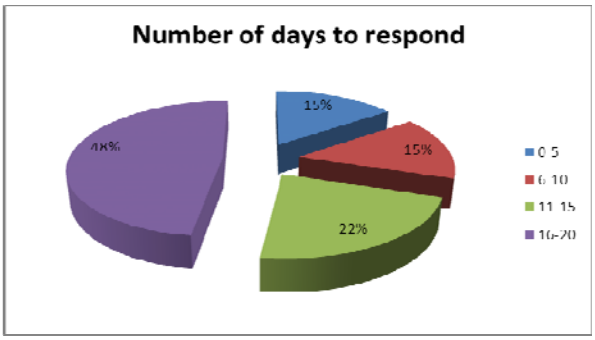
Alison raised concerns regarding the care and treatment her daughter, Kerry, had received from CAMHS following second overdose of over the counter medication. Alison explained that it felt like there was no communication between staff teams.

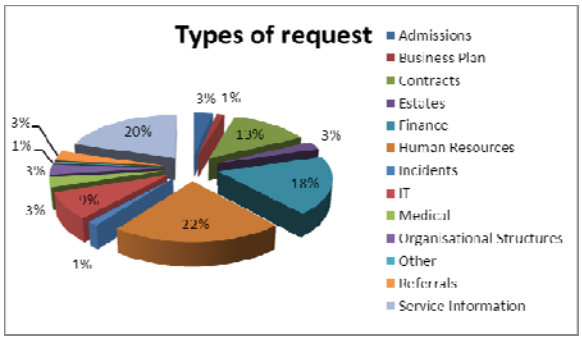
In response to the concerns raised, the CAMHS team reviewed the protocol for follow up appointments, and allocation of staff to cases relating to incidents of deliberate self-harm. The review has improved Communication within the team and the changes implemented support improved case management.

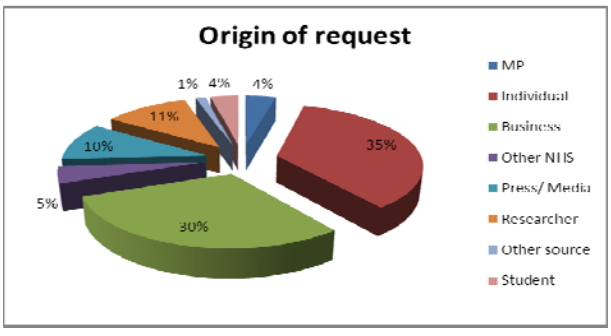
FREEDOM OF INFORMATION REQUESTS

226 requests to access information under the Freedom of Information Act were processed in the financial year 2014/15, an increase of 20 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, 5 requests were subject to exemptions under the Act - 1 under section 41, public sector contracts, 2 under section 43, commercial interests, and 2 under section 40, personal information.

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

The Trust Board now reviews feedback through Customer Services on a quarterly basis. Quarterly reports are also shared with Extended EMT, externally with commissioners as part of the contracting and quality monitoring processes, and with Healthwatch across our geography. Monthly reporting on complaints regarding staff attitude continues as part of the Trust's performance report.

During quarter 2, feedback was received following a Members' Council review of Customer Services activity, that a breakdown of themes between inpatient and community services would provide helpful insight. Coding updates currently being applied to the Datixweb electronic recording system, to support service line reporting, will mean that this breakdown will be able to be provided in future reporting.

Work is underway to develop combined reporting of patient experience, customer services and equality information to maximise the opportunity for triangulation and to extrapolate themes and areas of both concern and best practice. This work is being progressed as part of the customer experience sub group.

In quarter 2, KPMG completed a review of patient experience and engagement, as part of the Trust's internal audit programme. In respect of Customer Services, the review identified good practice, including Trust policy being in line with national good practice in NHS complaints handling and a robust and comprehensive framework for escalation and reporting of complaints data to Trust Board, Extended EMT and to BDUs.

The review also identified areas for development, including exploring further opportunities for supporting ward teams to learn lessons and implement change in response to feedback, and an action plan has been developed in response to this, with weekly updates provided to deputy directors, general managers and clinical leads regarding actions agreed through the Trust's response to complainants.

During quarter 3, the Customer Services policy was updated taking account of the CQC essential standards, the duty of candour and the internal audit report reviewing service user experience. Ongoing horizon scanning of best practice publications from regulatory bodies and patients associations continues with review against Trust procedures to promote ongoing learning and improvement.

The Customer Experience Group has been re-constituted, with a clinical lead as Chair and with a remit to work to a single reporting and governance framework to enable more robust triangulation of experience data. Membership of the group is also subject to review to ensure representation aligns with the new 'trio' structure in BDUs (clinical lead, general manager and practice governance coach).

The remit of the group is to:

- Maintain oversight of all initiatives to gather feedback about service user and carer experience and ensure high level co-ordination
- Triangulate feedback and commentary from service users, carers and volunteers, identifying themes and trends
- Ensure services are supported to make appropriate and timely response to feedback
- Ensure linkages with CQC and other regulatory bodies
- To identify and commission the top 5 task and finish development projects as a follow up to customer feedback.

Trust Board: 30 June 2015
Agenda item 8.1(iv)

Title:	**Health and safety annual report 2014/15 and objectives 2015/16**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible, risks are mitigated or reduced. This paper is devised to give assurance on the on-going management of health and safety in the Trust.
Mission/values:	Safety and effectiveness in a complex environment is vital to ensuring individuals receive care that enables them to live well in their communities.
Any background papers/ previously considered by:	The Clinical Governance and Clinical Safety Committee receives regular updates based on exception reporting.
Executive summary:	The health and safety annual report 2014/15 is designed to give an overview of the leadership and management of health and safety during the previous twelve months. In summary the attached annual report gives an update on: ➢ the structure within the Trust for the management and engagement of key stakeholders in health and safety; ➢ the monitoring and auditing of health and safety in the workplace and action taken; ➢ key health and safety risks and action to mitigate them; ➢ health and safety training activity; ➢ Trust response to changes in legislation; ➢ overview of health and safety incidents during 2014/15. ➢ Update on 2014/2015 Health and Safety Objectives The highlights from the report are as follows. ➢ The annual health and safety audit identified no high risk areas. ➢ The NHS Staff Survey identified an improvement in staff receiving Health and Safety Training but the Trust was still in the lowest 20% of similar organisations. This is in spite of a significant increase in people attending health and safety training. Other highlights from the survey were: - 71% of staff agree that senior managers promote a culture of patient/service user safety. - 82% of staff agree that there are clear and effective systems of reporting health and safety issues. - 77% of staff agree that there are sufficient measures in place to identify health and safety risk. ➢ Overall the number of participants undertaking safety training over doubled from 2348 to 5312 from 2013/14 to 2014/15. ➢ All reportable injuries, diseases and dangerous occurrences (RIDDOR) were investigated internally with no follow up required from the Health and Safety Executive. ➢ Moving and handling training was an area of concern and action has been taken to increase attendance and make the programme more accessible.

	➢ Slips, trips and falls incidents reduced by 5.5% from 2013/14 to 2014/15. ➢ The four key areas of risk in terms of health and safety remain on: - managing violence and aggression; - staff health and wellbeing; - patient slips, trips and falls; and - staff and visitors slips, trips and falls. The 2015/2016 action plan builds on the previous years and is designed to: ➢ continue to embed a robust risked based monitoring and audit programme; ➢ refine a set of key performance indicators to help manage risk and improve health and safety arrangements in the Trust; ➢ continue improve access to health and safety training; ➢ develop regular communication framework for health and safety; ➢ integrate at Trust-wide level health and safety, and emergency planning.
Recommendation:	**Trust Board is asked to APPROVE the health and safety annual report for 2014/15 and AGREE the action plan for 2015/16.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual Health & Safety Report 2014/2015 and 2015/2016 Action Plan

Roland Webb
Health & Safety Manager
June 2015

CONTENTS

Health & Safety Annual Report 2014/2015 and Annual Objectives 2015/2016

1 Introduction

This report is designed to provide an overview of the management of Health & Safety within the organisation during 2014/2015 and the key areas for developments in 2015/2016.

A significant amount of work has been undertaken throughout 2014/2015 to ensure the Trust continues to effectively manage health and safety risks and a number of key issues have been addressed over the past 12 months. It is, however, important to acknowledge the health and safety agenda continually develops with new legislation, outcomes of national reviews or enquiries and organisational learning.

The 2015/2016 Health & Safety action plan builds on the achievements of the 2014/2015 plan and addresses key risks identified in the year.

As in 2013/2014 whilst there has been no new significant health & safety risks, Health and Safety staff have continued to take a proactive approach by working with managers, staff, partner organisations and stakeholders in an effort to mitigate identified risks.

2 Health and Safety Structure

The Trust has a well defined structure to ensure health & safety matters can be effectively discussed and where appropriate action agreed. The overarching Health and Safety TAG meets quarterly and considers the strategic issues whilst two local Sub-Groups meet bi-monthly tackle operational Health & Safety issues in the Trust and feed into the overarching TAG.

Issues covered by the TAG and Sub-Groups include Fire, Moving & Handling, Security, Waste Disposal, Emergency Planning, partnership working, risk assessments and horizon scanning issues.

A new development for 2015/2016 is the Health & Safety TAG merging with the Emergency Preparedness Trust Action Group to give a strong approach to risk management.

3 Trust Wide Annual Health and Safety Monitoring

The Clinical Governance Support Team (CGST) was again commissioned by the Health and Safety TAG to undertake the annual audit of general health and safety issues. The CGST provided vital support with the questionnaire design, analysis and report.

All the BDUs achieved between 81% and 86% compliance. No significant risks were identified and any lower than expected scores have been addressed through action plans**,** with the Health & Safety Team following these up to support individual services.

The Trust's Health & Safety monitoring tool continues to be the major vehicle for auditing health and safety practice and management, and it supports the proactive health & safety management at a local level.

3.1 Aim

The aim of the audit was to provide a review of health and safety management across the Trust and identify any gaps.

The audit gives a comprehensive view of health and safety issues within BDUs with the following objectives:-

- To monitor health and safety areas across the Trust
- To highlight areas of good practice and areas of concern
- To ensure that an action plan is provided for areas of concern that will feed into the Health & Safety annual improvement programme.

The 2014/2015 audit tool was significantly revised by the project team. The tool was designed in Survey Monkey a web based survey programme. The link to the survey was circulated via a targeted email. Regular updates were placed in the weekly bulletin and on the intranet pages.

CGST provided the number of returns weekly which were monitored by the Health and Safety teams. CGST completed the analysis and production of this report.

3.2 Report structure

The Trust wide audit of health and safety took place during December 2014. The audit tool had several sections and the results are presented within these sections. Each section provided the results for the survey as tables and the overall compliance level for the standard. To assess the 'self-declared' level of compliance, the results were calculated on the actual 'yes' and 'no' responses. There were a number of 'not applicable' responses which were not included in the overall percentage but the numbers shown. Missing data was also not included in the overall percentage.

A section showing the Quality Health results for the health and safety questions from the 2014 national staff survey is also included.

3.3 Results

A total of 165 surveys were submitted and downloaded from Survey Monkey by the Clinical Governance Support Team.

- 40 Barnsley BDU
- 45 Calderdale and Kirklees BDU
- 12 Forensic BDU
- 13 Specialist Services BDU
- 17 Wakefield BDU
- 38 Corporate and Support Services

3.4 National NHS Staff Survey Results

This section provides the results from some questions in the National NHS Staff Survey which directly map to the Health and Safety Executive (HSE) Management Standards.
The results below are provided by Quality Health (QH). There were 374 respondents from the Trust in 2014.

In the core questionnaire staff were asked if they had received any health and safety training, of which 66% (233) had received training in the last 12 months, 28% (97) more than 12 months ago and 6% (21) said no; 4 cases stated not applicable to them and there were 19 missing.

Table 1 shows the results of the questions asked in the optional health and safety module.

Table 1: NHS Staff Survey optional questions

NHS Staff Survey Health and Safety optional questions 2014	Strongly agree or Agree	Neither Agree or Disagree	Strongly disagree or Disagree	Data missing
Senior managers in this organisation promote a culture of patient / service user safety.	71% (262)	25% (91)	4% (15)	6
There is a clear and effective system of reporting health and safety issues across this organisation.	82% (300)	14% (51)	4% (15)	8
Sufficient measures are in place to identify health and safety risks in this organisation.	77% (284)	19% (69)	4% (13)	8
Staff are encouraged to carry out routine risk assessments.	74% (271)	20% (73)	6% (23)	7
Staff are encouraged to challenge safety practices if they are not working.	69% (252)	24% (88)	7% (27)	7
Patient / service user safety is never sacrificed to get more work done.	52% (192)	32% (116)	16% (58)	8
Staff uphold good safety standards in this organisation.	77% (284)	21% (76)	2% (7)	7
In my team / department, we discuss ways to improve staff / patient safety.	68% (250)	25% (90)	7% (27)	7
Patient / service user feedback is taken into consideration when evaluating ways to improve safety.	56% (204)	37% (135)	7% (26)	9
We have patient / service user safety problems in this organisation.	22% (80)	45% (164)	33% (119)	11

3.5 Reviewing Results and Action Planning

All the self-assessment returns are reviewed for any high risk issues where immediate action needs to be taken. This review identified no high risk issues. The self declaration are then graded as shown below based on level of compliance.

	91% - 100% compliance achieved
	81% - 90% compliance achieved
	Less than 81% compliance achieved

The compliance achieved is then used to develop the local action plans which is then monitored in the next audit.

In summary all the BDUs achieved between 81% and 86% compliance. No significant risks were identified and any lower than expected scores have been addressed through action plans.

4 Safety Related Training

Overall the number of participants undertaking Safety related training during 2014/2015 increased from 2348 in 2013/2014 to 5512 during the last financial year. Safety related training in this context excludes additional training provided by the Fire, MAV and IPC teams.

Despite this increase the NHS Staff Survey nevertheless still indicated that staff are not always aware that safety related training covers a wide spectrum of programmes. Additional work to publicise health and safety training will be undertaken in 2015/2016.

There remains significant pressure in the Trust to be able to deliver Health & Safety Training and the Health & Safety team will continue to invest time working with services to offer and deliver flexible solutions.

Services do seem to prioritise training as per the Trust mandatory training schedule, but the recent NHS Employers Health and Safety Competences for NHS Managers reinforces the HSE message that such training is a legal requirement.

Courses – 2014/2015	**Numbers**
Conflict	47
Conflict Refresher	134
Conflict Resolution E-learning (including Personal Safety) -	376
COSHH E-learning	5
DSE E-learning	92
Emergency First Aid	24
First Aid at Work Certificate	54
First Aid at Work Refresher	27
H&S & Risk Assessment (1 class)	24
H&S Awareness	340
H&S Awareness E-Learning	24
Lone Worker	3
M&H Basic E-learning	2790
M&H Hoist	60
M&H Link worker	14
M&H People	542
M&H Specialist Workshops	175
M&H Workbook	368
Welcome Event	413
Total	**5512**

5 RIDDOR

RIDDOR, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 requires the Trust to report over seven day injuries to the Health & Safety Executive. The Trust Health & Safety Team reported 32 such incidents during 2014/2015.

	Inappropriate violent/aggressive behaviour (not against person) by patient	Injury following MVA	Moving and Handling / Working environment issues (e.g. office layout)	Physical aggression/threat (no physical contact): by patient	Physical violence (contact made) against staff by patient	Slip, trip or fall - staff member	Unintended/ Accidental injury	Tot
Barnsley Mental Health and Substance Misuse (BDU)	0	0	0	1	2	0	1	**4**
Barnsley General Community Services	0	0	0	0	0	3	0	**3**
Calderdale	0	0	0	0	1	0	0	**1**
Kirklees	0	0	1	0	0	1	1	**3**
Wakefield	0	0	0	0	3	0	0	**3**
Forensic Service	1	3	0	1	6	3	1	**15**
Specialist Services	0	0	0	0	0	1	0	**1**
Trust wide (Corporate support services)	0	0	0	0	0	1	1	**2**
Total	**1**	**3**	**1**	**2**	**12**	**9**	**4**	**32**

There was no follow up by the Health & Safety Executive on any RIDDOR notifications, which are used by the HSE as a basis for determining whether a formal investigation is required.

Every RIDDOR notification was investigated by the Health & Safety team, who also liaised with other colleagues and teams where appropriate, i.e. MAV, Legal, Services

6. Moving and Handling 2014-2015

Training

Over the year 2014-15 the advisers have introduced an alternative training strategy including the introduction of workplace based workshops and a workbook to support the existing classroom based and online training offers. This has shown a marked improvement in the mandatory training figures in comparison to previous years. The combined figures for all mandatory training offers have risen from 24.7% in 2013-14 to 70.1% in 2014-15. This year's figures can be broken down further to 73.6% of staff Trust wide completing the basic mandatory training requirement for all roles across the Trust either by Elearning or by the recently introduced workbook. The Health and Safety team recognises that this still does not meet the 80% target figure for this level of training and will continue to work with Learning and Development to look at strategies to meet future targets.

The new 2014-2015 training strategy requires that clinically based staff who work directly with individuals either in the inpatient areas or in the community are required to complete an additional level of training as part of their mandatory requirement, the current uptake for this training is 57.04% in 2014-15 (no comparison is available due to changes in strategy from previous years). There are sufficient places required for all staff to have an opportunity to attend these classroom based sessions (980 staff identified), however, while the places on these sessions are consistently fully booked there is an issue with non-attendance on the day. Again the advisers are working with Learning and Development and operational managers on strategies to improve this situation.

Sickness/Absence

Sickness figures show that absence due to musculoskeletal health remains the same proportion of the overall rate as the previous year at 21%. However, the figures also show a downward trend in the number of sickness/absence days taken due to musculoskeletal health problems from 15,535 in 2013-14 to 12,389 2014-15. Advisers continue to work with operational managers, staff and support services to identify potential risks associated with the moving and handling of both loads and people providing both advisory and practical solutions to introduce safer working practices at all levels across the Trust.

Datix

Datix incident reported figures have remained the same at 25 reported incidents 2014-15. These incidents generally remain low risk and are predominantly workplace/environmental issues. Two incidents were reported as yellow in the year and the team has responded to these incidents with appropriate assessment, training and support to individuals and mangers as indicated.

7 Slips Trips & Falls

	Barnsley Mental Health and Substance Misuse (BDU)	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Slip, trip or fall - other/visitor	0	5	1	1	1	0	0	1	9
Slip, trip or fall - patient	31	138	108	233	279	57	35	0	881
Slip, trip or fall - staff member	4	18	4	9	7	12	6	10	70
Total	35	161	113	243	287	69	41	11	960

A total of 960 (a 5.5% reduction from the 1016 reported in 2013 -2014) slips trip and falls incidents within SWYPFT were recorded with 9 resulting in an over 7 day absence and a RIDDOR notification. As a key safety risk, the Health & Safety team continue to work in close partnership with the Trust's clinical Falls Group to help ensure a coordinated approach to the issues.

8 Key Health & Safety Risks

A total of 5916 of safety related incidents were recorded in 2014/2015, showing a small reduction of 24 from the previous year and maintaining the 9.75% reduction from 2012/2013 reported statistics**. (see over the page)**

4 Key risks the Trust manages are:-

1. **Violence & Aggression**:- The Health & Safety team work closely with MAV colleagues at both a strategic and operational level, especially in the follow up to incidents, RIDDOR notifications. There is active representation from both Health & Safety and MAV teams on the respective TAG's and Sub-Groups.

2 **Health & Wellbeing:-** The Trust remains fully committed to working in partnership with all staff to help maintain and improve staff wellbeing, both in and out of work and has a well established Health & Wellbeing group with a number of initiatives in place to help support and encourage staff to maintain their mental wellbeing. Work includes cooperating with Robertson Cooper to help ensure effective strategies can be implemented to support staff

3 **Patient Slips, Trips & Falls:-** As referred to in section 7**,** the Health & Safety team work in close partnership with the Trust's clinical Falls Group to help ensure a coordinated approach to the issues in order to reduce the number of, and subsequent consequences of patient slips, trips and falls, particularly in the working clinical environment.

4 **Staff/visitor Slips Trips & Falls:-** The Health & Safety Team work closely with colleagues across the Trust, including Moving and Handling, Estates & Facilities and Capital Planning. The issue of slips, trips and falls is covered in safety training.

Analysing categories of purely health & safety related reported problems, "Staffing levels" at 294 reports were recorded, followed by "Unintended/Accidental injury" (129) and "Vehicle Incident" (122).

The 2015/2016 action plan includes measures to review the Trust Health & Safety Risk Assessment policy and Traffic Management/car Parking policy to help alleviate problems with reported Unintended/Accidental injuries and vehicle incidents.

There was an encouraging drop of 42% to 63 reports of Environmental issues (including waste issues/exposure to hazard/ animals and hygiene concerns), during the year.

	Barnsley Mental Health and Substance Misuse (BDU)	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Security breaches (including personal/buildings/theft and vandalism)	43	67	38	55	68	253	25	24	573
Health and Safety (including fire)	97	93	98	174	147	330	74	44	1057
Slips, Trips and Falls	35	161	113	243	287	69	41	11	960
Violence and Aggression	201	33	616	516	738	906	309	7	3326
Total	376	354	865	988	1240	1558	449	86	5916

9. Health & Safety Action Plan – 2014/2015

All eight actions from the 2014/2015 Health & Safety Action Plan have been achieved and signed off as completed the Health & Safety TAG – see over the page.

10 Health & Safety Action Plan – 2014/2015

A ten point action plan for 2014/2015 has been proposed – see pages 16 – 18.

Health & Safety Action Plan – 2014/2015

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Update – March 2015
1. Link in Occupational Health to RIDDOR process to facilitate fast track staff support for over seven day absences due to injuries at work.	Alan Davis/Jerry Murphy	Roland Webb/Helen Whitelam	Ensure effective cooperation between key Trust services	**Completed**	**Policy/Guidance approved and live**
2. Develop flexible, risk based inspection/audit programme and to formally RAG rate services, wards, teams as appropriate	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Richard Galliford	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	**Completed**	**Building on the existing audit programme, the formal RAG rating of services fine tunes existing audit/inspection processes and targets resources even more effectively at high risk teams/services.**
3. Implement regular Health & Safety publicity in partnership with the Communications Team and using a variety of mediums to suit. To include publicity stalls "promotional week", newsletter/intranet etc	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Richard Galliford	Ensure timely and relevant safety message is cascaded throughout the year	**Completed/On - going**	**Display boards revamped. Intranet pages updated Comms agreed to use of Trust screen saver. "H&S" week to organise**
4. KPI's – Develop framework to ensure accurate data of staff absence due to health, safety and well being issues	Alan Davis/Jerry Murphy	Roland Webb	To facilitate the detection of trends and subsequent analysis of hot spots in terms of staff absence	**Completed/On - going**	**Format agreed with AD – distribution of report to be decided. Report is likely to go HR Business Managers for BDU meetings, H&S, Wellbeing Group.**

5. Refresh, and develop Trust Health & Safety Training Programme ensuring branding of training is clear, concise and in line with the Quality Account Staff opinion survey	Alan Davis/Jerry Murphy	Roland Webb	Ensure health & safety is fit for purpose and accessible for all grades of staff.	**Completed**	**Training now being monitored and covered by monthly dashboard reports. Training programme revamped and publicised on intranet. Risk Assessment and Lone Worker training added, as is offer of bespoke training for individual teams**
6. Implement and complete audit/inspection programme by end of October and prepare for 2014/2015 monitoring programme	Alan Davis/Jerry Murphy	Roland Webb/ Richard Galliford/Steve Amos/	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	**Completed**	**Distribution list prepared. Audit programme out now for completion by managers by 24th December 2014. Analysis due by end of March 2015**
7. Update and refine clear reporting mechanisms for prompt and accurate reporting of incidents and near misses, underpinning risk identification through DATIX reports	Alan Davis/Jerry Murphy	Roland Webb/Richard Galliford/Steve Amos	Ensure the Safety team have access to relevant DATIX reports	**Completed**	**Distribution of DATIX reports updated to ensure H&S team receive reports applicable to their area. Previously, H&S advisors were being swamped with reports from out of area, causing confusion**
8. Fully develop effective and robust links with a range of key Trust Business partners, including local CiC's CCG's, CSU's Barnsley District Council and WMDC	Alan Davis/Jerry Murphy	Roland Webb	Develop a consistent Trust wide approach with Social Services partners in line with existing model	**Completed**	**Links now established with BMBC and joint working commenced. Also now have established links with WMDC following their re-organisation. WMDC joining us in programme of work with HSE, Working Well Together Group**

Health & Safety Action Plan – 2015/2016

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments
1. Review and update flexible, risk based inspection/audit programme and to formally RAG rate services, wards, teams as appropriate	Alan Davis/Nick Phillips	Roland Webb/ Steve Amos/ Richard Galliford	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	Q2	Building on the existing audit programme, the formal RAG rating of services fine tunes existing audit/inspection processes and targets resources even more effectively at high risk teams/services
2. Develop Environmental Policy with emphasis on safe and effective working practices	Alan Davis/Nick Phillips	Roland Webb	There is increasing demand for organisations to declare environmental and safety credentials in new business tenders	Q2	The Health & Safety Team are already actively supporting the Trust with tender bids for new and existing business
3. Health & Safety Risk Assessment policy update & review	Alan Davis/Nick Phillips	Roland Webb/ Steve Amos/ Richard Galliford	Revised policy will reflect training offer and NHS Employer's guidance on expected staff competencies	Q3	Existing policy expires in September

4. Develop Trust wide Personal Protective Equipment at Work (PPE) guidance	Alan Davis/Nick Phillips	Roland Webb/ Steve Amos/ Richard Galliford	Provision of improved guidance to managers & staff	Q3	Guidance follows on from experience in the year of staff affected by potential effects on health from incorrect use of PPE
5. Update and review Trust Health & Safety Training Programme ensuring branding of training is clear, concise and in line with the Quality Account Staff opinion survey	Alan Davis/Nick Phillips	Roland Webb	Ensure health & safety is fit for purpose and accessible for all grades of staff. Linked to staff survey that indicates lower than average attendance at Health & Safety Training	Q3	Effective training underpins effective delivery of Trust Safety policies and procedures and is a key element identified by the HSE in specific guidance, INDG345. Action by the Health & Safety Executive for failing to ensure staff are trained to undertake their role safely and competently is an ever present threat resulting in a constant review of Trust Health & Safety Training
6. Implement and complete audit/inspection programme by end of October and prepare for 2015/2016 monitoring programme	Alan Davis/Nick Phillips	Roland Webb/ Richard Galliford/Steve Amos/	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	Q3	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
7. Develop Central Risk Assessment Database, available for use by Health & Safety and Legal team	Alan Davis/Nick Phillips	Roland Webb/ Steve Amos/ Richard Galliford	To ensure quick and easy access to a range of key risk assessments completed by services	Q3	To facilitate shared learning across the Trust for possible solutions to risks identified

8. Develop Traffic & Parking Management Safety Policy	Alan Davis/Nick Phillips	Roland Webb/Johan Celliers	Traffic safety is a key element of consideration for the HSE	Q3	Reports over the last 12 months indicate traffic on Trust sites requires increasing control measures to maintain safety
9. Complete work of the Trust "Safer Sharps" group	Alan Davis/Nick Phillips	Roland Webb	Work of the Trust Safer Sharps Group has been successful since 2013 and will come to fruition in 15/16	Q4	The Health and Safety (Sharp Instruments in Healthcare) Regulations have been introduced by the Health and Safety Executive (HSE) to implement a European Directive. Work of the group will transfer to the H&S TAG/Sub-Groups
10. Develop and strengthen prevention of Slip, Trips & Falls for staff and visitors	Alan Davis/Nick Phillips	Roland Webb	Prevention of Slips, Trips & Falls for staff and visitors remains a key Trust priority	Q4	Program of awareness, publicity and dynamic risk assessments to be developed.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 8.1(v)

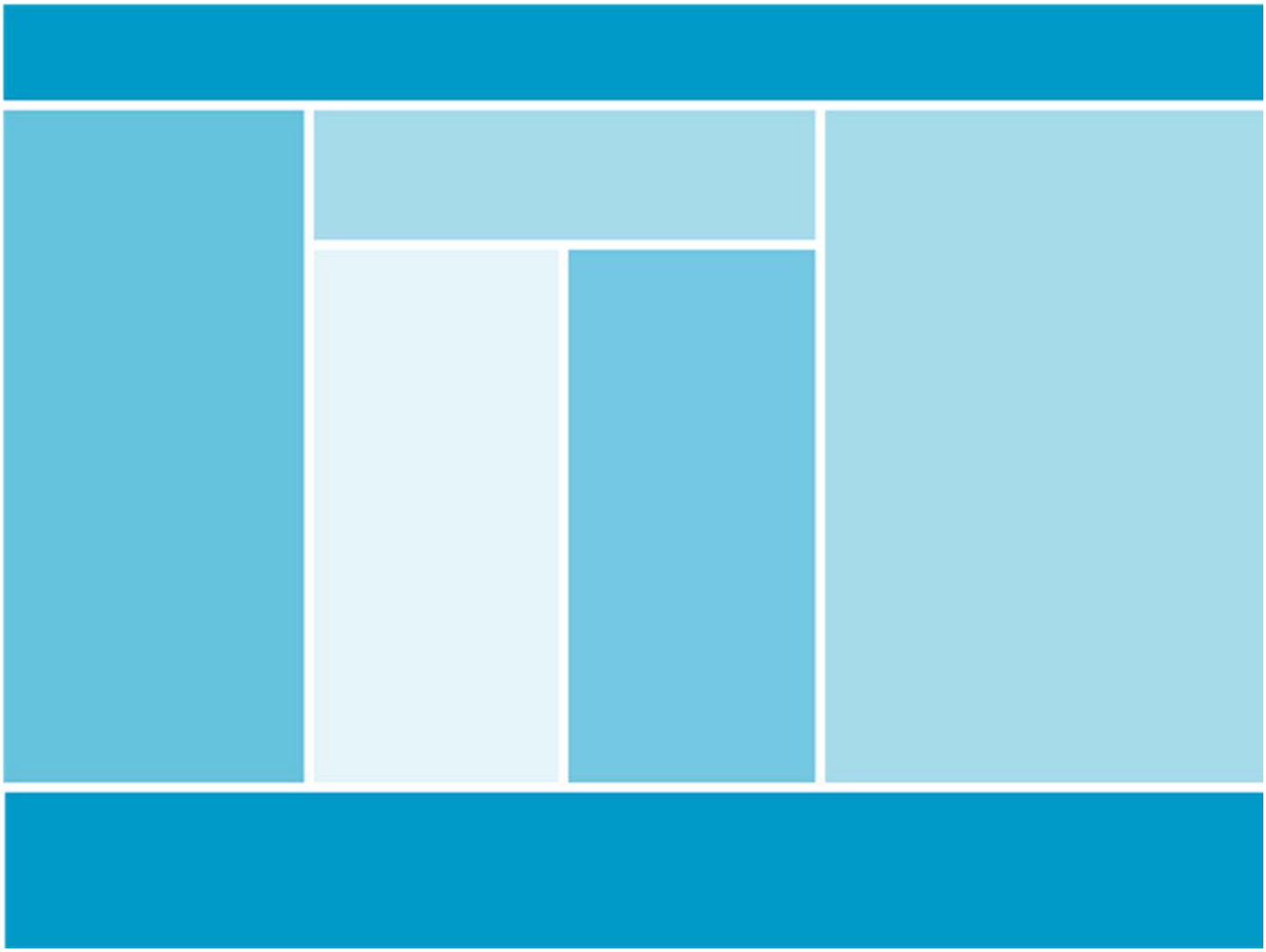
Title:	**Sustainability Strategy 2015/16 – 2019/20**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is twofold: ➢ to provide an update of progress against the Trusts sustainability targets; and ➢ to set out the Trust Sustainability Strategy for the next 5 years.
Mission/values:	The Trust's mission is to enable people to reach their potential and live well in their community. The Trust will not achieve this unless it ensures it is operating sustainably in the use of resources and how it works with local communities. Sustainability in the organisation is defined in its broadest terms as being a good corporate citizen.
Any background papers/ previously considered by:	Previous Sustainability Strategy 2010/15
Executive summary:	The overall purpose of this strategy is to provide a clear framework and vision of how the Trust will drive integration of sustainability into its operations and its engagement with staff, service users and the communities it serves. The strategy sets out realistic, measurable targets under each of the three national goals and each of the Good Corporate Citizen assessment headings. Specific areas covered are: - energy and carbon management; - procurement; - transport, travel and access; - water; - waste; - designing the built environment; - adaptation; - organisational and workforce development; and - partnerships and networks. A detailed implementation plan has been developed to support the delivery of the strategy with clear targets, timescales and milestones. The plan will be monitored and evaluated by the Sustainability Project Group every six weeks and by the Sustainability Project Board twice a year.
Recommendation:	**Trust Board is asked to NOTE the progress made to date against the Trust's sustainability targets and consider and APPROVE the five-year Sustainability Strategy.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Sustainability Strategy 2015/16 – 2019/20

Sustainability – be part of our solution



Contents page

1. Executive summary

Our mission is to enable people to reach their potential and live well in their community. We believe we will not achieve this unless we ensure we are operating sustainably, which in our organisation is defined in its broadest terms as striving to be a Good Corporate Citizen.

The overall purpose of this strategy is to provide a clear framework and vision of how the Trust will drive to integrate sustainability into its operations and its engagement with staff, service users and the communities we serve.

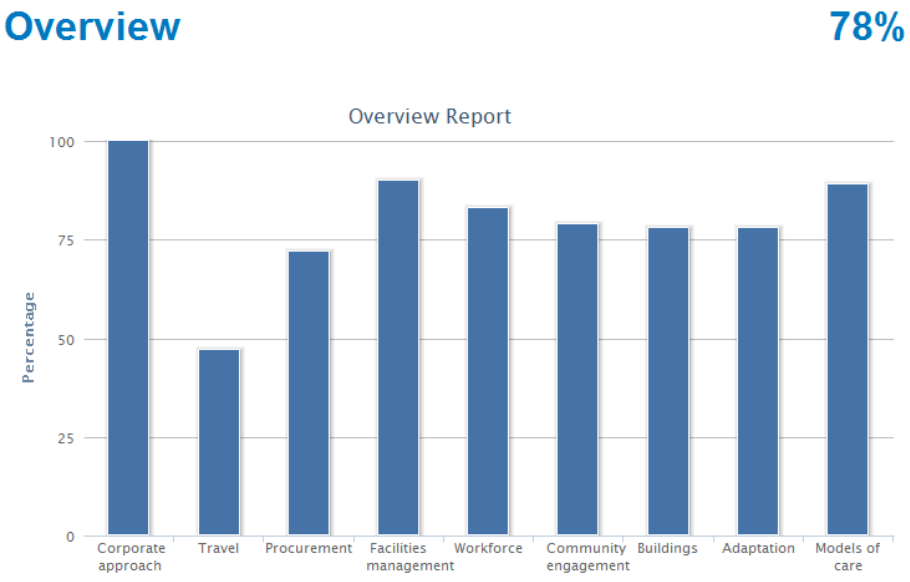
This strategy sets out realistic, measurable targets under each of the 3 national goals and each of the Good Corporate Citizen assessment headings. Specific areas covered are energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment, adaptation, organisational and workforce development and partnerships and networks.

We continue to use the Good Corporate Citizenship model which was developed by the Sustainability Development Commission and the Department of Health as it echoes our Trusts belief in the importance of inclusion and co-production.

Community engagement and workforce involvement are the cornerstones to success in all areas of our work - we know that we will only succeed if we continue to harness the commitment and support of our staff and volunteers to behave and work in a sustainable way.

For the purpose of this strategy we are using the 3 national goals and the 9 areas of focus within the Good Corporate Citizenship model.

Our current score is 78% which is very good and we compare extremely well against other organisations that have chosen to complete the assessment. We can improve all areas but the main area for development is in Transport, Travel and Access.



Making you a Good Corporate Citizen, Sustainable Development Unit (2015)

Our main challenges for 2015/16 are:

Energy and Carbon Management
We have already met our target to reduce our levels of CO2 emissions (electricity and gas, car/motor travel, waste and water) by 18% by 2016. We have set another target to further reduce - 34% reduction by 2020 (from a baseline of 2010/11 levels).

Procurement
We continue to procure our services using the whole life costing model and for the future we intend to stretch ourselves further by increasing the level of business engagement with local small / medium enterprises.

Transport, Travel and Access
In 2015/16 we will develop a comprehensive sustainable travel plan which includes an active travel plan for staff, people who use our services, their carers, visitors and people who volunteer their time with us. This will have a significant impact on our score in the Good Corporate Citizenship model.

Water
We will continue to reduce our water consumption using water efficient technologies.

Waste
We are really good at managing our waste! But in 2015/16 we going to encourage innovation and support new methods of further reducing our waste through our waste / recycling contracts (e.g. energy recovery, conversion to building materials).

Designing the built environment
In the year ahead we want to improve high quality green space and biodiversity on our estate, because we know that this helps people feel better.

Adaption - ensuring we can cope with the impact of climate change.
We will work closely with our partners to make sure that our plans line up with theirs so that if bad weather hits us we can deal with it.

Workforce and organisational development
We are going to continue to work with people who use our services, their carers, our staff and our volunteers to harness their enthusiasm for and understanding of sustainability in all its forms so that we all behave and work in a sustainable way.

Partnerships and networks
In the year ahead we will continue to lead on and embed Creative Minds across our organisation and with our partners.
In 2014 we began to develop our vision for volunteering - we will continue to develop this in 2015/16 working towards gaining Investors In Volunteering

Accreditation in 2016 (the UK quality standard for good practice in volunteer management).

A detailed implementation plan has been developed to support the delivery of this strategy with clear targets, timescales and milestones. This plan will be monitored and evaluated by the sustainability project group every 6 weeks and by the sustainability board twice a year. We will repeat the Good Corporate Citizenship assessment in February 2016 with the aim of our score being 88%.

2. Background

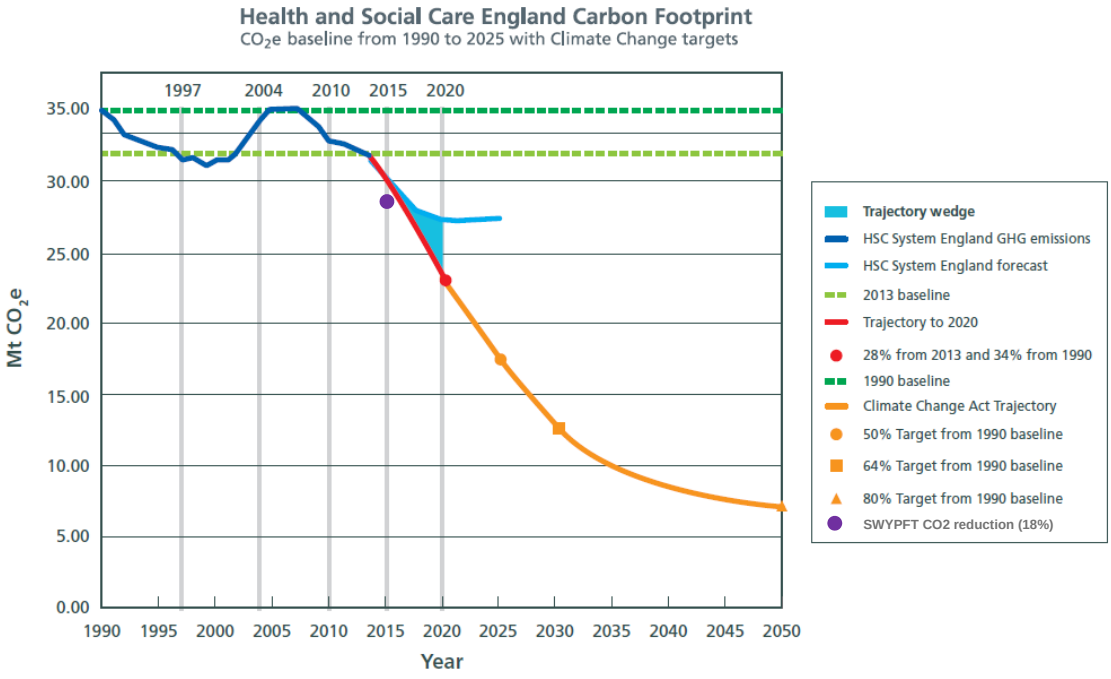
For some time there has been a strong scientific consensus that the effects of climate change on climate and financial stability, as well as public health, are already being seen. These effects will increase significantly if significant action is not taken by all of us. At the same time there are finite natural resources available to an increasing global population.

The NHS, with its focus on improving health and wellbeing and preventing illness has a major role to play in improving sustainability. It is the largest employer in Europe with the largest property portfolio. It has an annual budget of around £100 billion a year. It therefore is in a prime position and has the influence and capability to make a difference.

The NHS can make a difference in many ways such as being an employer, purchaser, manager of transport networks, consumer of energy, waste and water, a landholder and commissioner of building work and an influential partner in many communities.

The NHS as a whole has an important role to play in tackling Climate Change as it is responsible for 25% of the total public sector carbon emissions and 3.2% of the total carbon emissions in England.

There is an ambitious national aspiration for the health and care system to achieve a 34% reduction in its carbon footprint - building energy use, travel and procurement of goods and services between 1990 and 2020.



NHS, Public Health and Social Care Carbon Footprint 2012 (published January 2014)

At a national level the government strategy for sustainable development '*Sustainable, resilient, healthy people and places'* Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014-2020 provides the mandate for the entire health and social care system to work together.

The national strategy outlines a vision and 3 goals for the whole system to aim for by 2020.

Goal 1: A healthier environment

A healthier environment can contribute to better outcomes for all. This involves valuing and enhancing our natural resources, whilst also reducing harmful pollution and significantly reducing carbon emissions. Contributing to the Climate Change Act target with a 34% reduction in carbon emissions by 2020 is a key measure of our ambition across the country. (A further 64% carbon reduction by 2030, (based on 1990 levels) followed by 70% carbon reduction by 2050 (based on 1990 levels) is expected).

Goal 2: Communities and services are ready and resilient for changing times and climates

When periods of heat, cold, flooding and other extreme events occur it is vulnerable people and communities that suffer the worst. Those communities and their services bear the responsibility of addressing the consequences of these events. Multi-agency planning and organisational collaboration, underpinned by local plans and assurance mechanisms, provide a better solution to these events than working independently, individually and ineffectively.

Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments

Every contact and every decision taken across the health and care system can help build the immediate and longer term benefits of helping people to be well and reduce their care needs. There are multiple mechanisms that can support this approach from improved information, more integrated approaches and smarter more aligned incentives that help minimise preventable ill-health, health inequalities and unnecessary treatment. A sustainable system cannot be achieved without taking every opportunity to support communities and people to be dependent and self-manage conditions and events.

Sustainable development aims and principles

Sustainable development aims to ensure the basic needs and quality of life for everyone are met, now and for future generations.

Its guiding principles are:

- **Ensuring a strong, healthy and just society**
- **Living within environmental limits**
- **Achieving a sustainable economy**
- **Promoting good governance**
- **Using sound science responsibly**

From Sustainable Development in Government

So what does sustainability mean to us?

For our Trust, sustainability isn't just about the environment; it's about our whole approach as an organisation to sustaining ourselves, our service users and our local communities.

This is a complex piece of work and we know there isn't one simple action that can achieve the aim of 'being sustainable', nor can we do it alone. But by working together and making small changes where we can, collectively we can make our own solution for a better future. We can sustain ourselves and help sustain our communities – being a good corporate citizen.

The 3 goals from *'Sustainable, resilient, healthy people and places'* are the foundation upon which the Trust will move forward by considering them in strategic, commercial and operational decisions.

Sustainable development is often referred to as good corporate citizenship and we know that behaving as such can save money, support the people we serve and can help reduce health inequalities. Many measures that improve health also contribute to sustainable development and vice versa. We will use the good Corporate Citizen Tool, which is a national assessment framework created by the Sustainable Development Unit (SDU) which works across the NHS, public health and social care

system to assess and benchmark progress not just by measuring fuel bills or waste, but by evaluating sustainability across the board in financial, social and environmental terms.

Our current self-assessment using this tool is encouraging but through the delivery of this strategy we aim to improve our position from 76% to 86% over the next 3 years.

Our sustainability strategy sets out realistic, measurable targets under each of the 3 national goals and each of the good corporate citizen assessment headings. Action plans are being developed to facilitate delivery. The high level commitments made by the Trust for each of these are as follows.

3. South West Yorkshire Partnership NHS Foundation Trust – sustainable commitments

3.1 Goal 1: A healthier environment

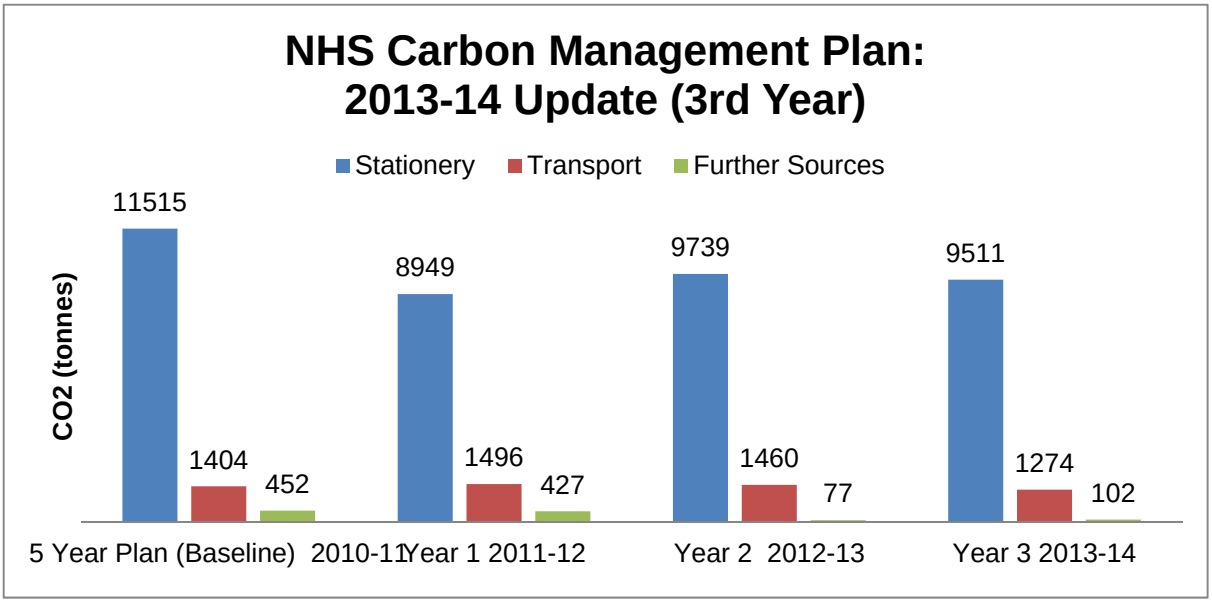
3.1.1 Energy and Carbon Management

Our achievements in the last three years:

The Trusts 5 year Sustainable Development and Carbon Reduction Plan (*Sustainable development and carbon management plan*) aimed to reduce CO2 by 18% by 2015/2016 (from a baseline of 2010/11 levels) and focused on 3 areas:

- Stationery sources – electricity and gas
- Transport – car/motor travel
- Further sources – waste and water

We will have achieved this 18% target in 2014/15.



Variation on baseline	Stationery	Transport	Further Sources	Total reduction
	-17.40%	-9.23%	-77.43%	- 18.58%

The overall trend for the Trusts energy consumption remains on its downward trajectory overall. The changes to the in-year figures are based on a number of differing factors which affect the base load these are as follows:-

- In 2012/13 the Newton Lodge scheme began to be handed back increasing the overall consumption for the Trust from the previous years.
- There have been marked changes in the weather during the period we are measuring; the results are not weather corrected so these variations do impact on our consumption.

Whilst the in-year rise for 2012 is explained it does affect our performance so the internal metrics the Trust adopts for energy performance need to allow for this and reference the effects of climate change on weather patterns. These more detailed metrics are measured at Sustainability project group so that changes can be assessed in more detail.

Overall the Trust is achieving its goals in terms of reducing consumption and the trend shown in the longer term results from the base year evidences this trend, further reductions will increasingly be predicated on a reduced estate footprint as the Trust adopts agile working principles.

Trend Building Management Systems (BMS) are now in place in all of our directly managed sites. These are computer-based systems that help to manage, control and monitor building technical services and the energy consumption of devices used by those buildings. The system also provides the information and the tools needed both to understand the energy usage of their buildings and to control and improve energy performance.
(Properties that are not managed by us or where the gas expenditure is below £7,000 pa i.e. small/domestic properties it is not a cost effective exercise to install). There is a rolling programme to replace the Schneider BMS Controls in Barnsley by 2017.

The Trust has rolled out a new fleet of print and multi-functional devices, creating a more efficient print solution for staff to use. This has reduced the number of devices in use and will enable the Trust to:

- reduce CO2 emissions generated by these devices from 182,503kg to 157,027kg
- reduce electricity consumption from 223,285.49 kW to 182,456.30kW

And taking into account savings made on paper, lease of photocopiers, toner and the purchase of printers make an overall saving of approximately 335k per year.

Our commitment
Reduce our energy consumption and greenhouse gas emissions in line with the UK Emission Reduction Targets (set against the Baseline Emissions in 1990)

- 2020 - 34% reduction (from a baseline of 2010/11 levels)
- 2080 – 80% reduction (from a baseline of 2010/11 levels)

- Successfully identify and deliver opportunities for energy efficiency and where feasible introduce low carbon technologies and renewable energy sources.
- Help staff to take responsibility for energy reduction measures within their departments
- Target specific areas for improvement and work with building users to reduce energy consumption through awareness campaigns

How will we achieve it?

- Regularly record and monitor our consumption to better understand our energy use
- Ensure robust assessment methods and detailed feasibility studies are conducted with all energy efficiency projects
- Help people who use our services , staff and people who volunteer their time with us to understand energy efficiency by providing the tools, awareness and information necessary

How will we measure it?

- Through Energy Manager software –

    - Monitoring and Targeting the use of utilities
    - Reporting to specific audiences
    - Reporting on consumption and cost of each utility (electricity, gas and water)
    - Monthly, quarterly and 6 monthly (also including CO2 emissions)

3.1.2 Procurement
Our achievements in the last three years:

We have a *sustainable Procurement Strategy* *http://nww.swyt.nhsuk/docs/Documents/922.pdf* with clear sustainability principles within it.

We use whole life costing whenever we can – this means when we buy a piece of equipment – whether that be a small piece of medical equipment or materials to be used in construction of a building – we consider how much that piece of equipment costs to buy initially, to maintain throughout its use and the costs to dispose of it. We also considers what costs will be involved in its use, which could include the labour cost for the member of staff who will be using it or the equipment's use of energy such as electricity, gas or water. Taking into account all of these costs enables us to decide if this is the right piece of equipment or material to buy.

Our commitment:

- To increase our business engagement with and support to small/medium businesses in our local communities
- Ensure sustainable goods, services and products are sourced on behalf of the Trust
- We will make sure our procurement strategy is ambitious with stretching targets for improving our performance further

How will we achieve it?

- Evaluate environmental and sustainability in all goods and service tenders
- Work with suppliers who are environmentally aware and hold the relevant accreditations
- Raise awareness and develop internal skills within procurement to enable positive change
- We will monitor and increase the level of business engagement with local small / medium enterprises with the aim of improving the stability of our local economy

How will we measure it?

- We will monitor and report on the social, environmental and economic impacts of our procurement decisions
- We will continue to work within national, regional and locally agreed contracts arranged by the Crown Commercial Services, NHS Supply Chain, Regional Procurement Hubs which have environmental, sustainable and ethical procurement standards and requirements within them
- Continue to ensure compliance with the Trusts Supplier Code of Conduct.
- Reporting the level of contracted expenditure in excess of its quotation threshold of £5K on the procurement team's operational dashboard.

3.1.3 Transport, Travel and Access

Positives examples / achievements in the last three years:

We work closely with other parts of the organisation to ensure a coordinated approach to healthy, sustainable travel planning (e.g. by implementing a cycle to work salary sacrifice scheme, providing good cycle storage facilities and by promoting a car-sharing scheme).

We have in place 'We're here' guides to every one of our buildings where we provide our clinical services from. All have been tested individually with people who use our services and their carers to ensure they are easy to understand and relevant. We aim to promote the use of public transport through these guides.

Our commitment:

- Where possible reduce carbon emissions arising from travel by staff, people who use our services, their carers', visitors and people who volunteer their time with us

- Reduce carbon emissions from fleet, grey fleet and business travel
- Promote the use of public transport, green travel initiatives and schemes
- Promote 'active' travel to encourage staff, people who use our services, their carers', visitors and people who volunteer their time with us to take regular exercise

How will we achieve it?

- Develop and regularly review a comprehensive sustainable travel plan which includes an active travel plan for staff, people who use our services, their carers', visitors and people who volunteer their time with us.
- Improve travel facilities and offer a range of training and incentives for staff to encourage active travel (e.g. cycle to work salary sacrifice scheme, bike loans, cycle mileage rates competitive with driving rates)
- Phase out high carbon emission forms of transport and replace with low carbon alternatives
- Promote use of public transport for our staff, people who use our services, their carers, visitors and people who volunteer their time with us and support purchasing of travel passes
- Continue to deliver our agile working plan – ensuring staff work in an 'agile' way for the benefit of our services – working effectively, flexibly and efficiently, reducing unnecessary staff travel, making the best use of the technology available to us and using our estate effectively – all contributing to reducing our carbon footprint.
- Utilise specialist advice from the NHS Sustainable development unit (SDU), department of health and other specialist organisations

How will we measure it?

- Monitor forms of transport, fuel types and distance travelled and benchmark ourselves internally and externally
- Undertake questionnaires and collect data from our staff, people who use our services, their carers', visitors and people who volunteer their time with us and use this information to inform our travel plans
- Monitor and encourage green travel take up
- Continually evaluate our agile working plan and its effectiveness

3.1.4. Water

Positives examples / achievements in the last three years:

We have reviewed our water use and developed ambitious plans to reduce our water demand and improve our water efficiency by 15% over the next 3 years

Our commitment:

- To continue to implement water metering, monitoring and leak detection
- Reduce our water consumption using water efficient technologies
- Consider water efficiency with all maintenance, refurbishment and new build projects including catering, laundry and facilities contracts specifying low water

use and that Water Regulations Advisory Scheme (WRAS) approved products are used

How will we achieve it?

- Install water saving/ conservation devices/meters as standard into building and refurbishment projects
- Influence the behaviour of staff, people who use our services, their carers', visitors and people who volunteer their time with us towards water efficiency through providing knowledge, awareness and support

How will we measure it?

- Through Energy Manager software
- Monitoring and targeting the use of utilities
- Reporting to specific audiences
    - On consumption and cost of each utility (electricity, gas and water)
    - Monthly, quarterly and 6 monthly (also including CO2 emissions)

3.1.5. Waste

Positives examples / achievements in the last three years:

As a Trust we are really proud of the way we handle, recycle and reduce our waste. We set a leading example of sustainable waste management and we know we demonstrate that our approach is leading to a continual reduction in absolute levels of waste in our organisation. We save 18 tonnes of landfill per annum.

Our commitment:

- Monitor waste streams and ensure compliance with waste legislation
- Ensure waste is managed legally, effectively and cost efficiently
- Ensure that we always dispose of hazardous biological, chemical, metal, electrical, cytotoxic/cytostatic and sharps wastes responsibly
- Meet waste reduction targets set as a minimum and where viable reduce waste further
- Reduce fuel usage and transport emissions associated with the transportation of waste
- Encourage innovation and support new methods of reducing waste through our waste/recycling contracts (e.g. energy recovery, conversion to building materials)

How will we achieve it?

- Assess and divert existing waste streams to increase recycling where feasible
- Review wastes volumes in relation to their risks and the environmental impact of their final disposal
- Encourage paperless offices and other waste reduction indicatives
- Influence the behaviour of staff, people who use our services, their carers', visitors and people who volunteer their time with us towards waste recycling by providing knowledge, awareness and support

How will we measure it?

- Regular audit of sites and buildings
- Review and reporting of data provided by contractors
- Monitor waste streams and waste to land fill

3.2 Goal 2: Communities and services are ready and resilient for changing times and climates

3.2.1 Designing the Built Environment

Positives examples / achievements in the last three years:

Where appropriate new schemes are monitored using the BREEAM (building research establishment environmental assessment method) healthcare environmental and sustainability standard, and all our new buildings achieve an 'excellent' rating with refurbishments at least a 'very good' rating.

For many of our buildings the ability to monitor energy usage at an individual ward/department sub level is built into the engineering design of the building. We are proactive in communicating the performance of our buildings to their users, and we promote the benefits of sustainable design to others.

We challenge contractors we work with to reduce the carbon emissions associated with the construction process, and set objectives for the use of recycled and low carbon building materials, and minimisation of construction waste.

Our commitment:

- Work towards integrating health and sustainable development considerations in our buildings
- Work closely with our local strategic partnerships and stakeholders to promote the delivery of health and sustainability outcomes, when planning our buildings
- Improve high quality green space and biodiversity on our estate, because we know this makes people feel better

How will we achieve it?

- Continue to deliver projects to upgrade buildings as set out in the Carbon Management Plan
- Work closely with our partners and suppliers finding new innovative ways to work better together.
- With partners plan, protect and promote the use of green space across our local area

How will we measure it?

- Achieving BREEAM outstanding ratings for our new buildings and major refurbishment projects
- Monitor and report on social, environmental and economic impacts of our building and refurbishment projects, including carbon emissions
- Gather evidence on the value of green spaces to people and biodiversity on our estate in supporting their health and well-being.

3.2.2. Adaptation – ensuring we can cope with impact of climate change

Positives examples / achievements in the last three years:

We have in place a Climate Change Mitigation and Adaptation Plan *(Climate Change Mitigation and Adaptation Plan)*

We have good plans in place with our partners in the event of extreme weather events so that all essential services continue and our staff can continue to support service users in the community.

We are an exemplar organisation in championing support to vulnerable people and are building our capacity and capability to manage this in a harmonised manner.

Our commitment:

- Work with our local health and wellbeing boards and other partners to ensure that adaptation is a key part of local planning processes
- We will work closely with our partners to make sure that our plans line up with theirs so that when extreme weather hits we are ready for it
- Become even better in our management of major and extreme events and will incorporate the impacts of climate change into the scenarios utilised for testing our plans

How will we achieve it?

- By working within and achieving compliance with NHS England's Emergency Preparedness, Resilience & Response Assurance Framework

How will we measure it?

- Regularly audit, inspect and testing of all our plans against the national framework with all of our partners

3.3 Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments

3.3.1 Organisational and workforce development

Positives examples / achievements in the last three years:

We have an active communications strategy to raise awareness about sustainability at every level of the organisation and to promote leadership competencies and deliver carbon reduction. This includes a film which focuses on four areas; procurement, community venues, waste recycling and energy and uses motion graphics, 3D to promote the small actions that staff can take in order to make a big difference towards a more sustainable future.

Our workforce strategy sets a leading example, with independently verified positive impacts on health, wellbeing and sustainable development. We have a range of services to support staff to maintain their emotional, mental and physical health and we carryout regular employee feedback surveys.

Our commitment:

- We are going to continue to work with people who use our services, their carers, our staff, and our volunteers to harness their enthusiasm for and understanding of sustainability in all its forms so that we all behave and work in a sustainable way
- Ensure that our strategy for sustainability is well understood
- Integrate sustainability roles and responsibilities into all levels of management and staff
- Become sustainable through a range of organisational development initiatives and schemes

How will we achieve it?

- Develop a multi-level awareness programme which ensures that our staff understand the environmental, financial and social opportunities afforded by running a more sustainable system
- Supporting staff to adopt more sustainable ways of working which will deliver benefits to people who use our services and the community
- Include sustainability in workforce training and development
- Support staff to use Information and Communication technologies to achieve further carbon reduction

How will we measure it?

- Encourage staff to generate ideas for improving sustainability within the Trust and regularly report on them
- Collect and review data from our awareness programme.

3.3.2 Partnerships and Networks

Positives examples / achievements in the last three years:

We have innovative plans for the future that see a step change in our engagement activities with all of our stakeholders and these are supported by evidence of effectiveness. We set a leading example of partnership working across the health and social care system and at all times seek to learn from our own and others' experience.

We use creative approaches and activities in our services. Creative Minds provides a framework enabling creative partnerships to flourish across communities we serve, developing projects for local people which are both co-funded and co-delivered with community partners. This has harnessed a shared passion for the arts, sports, crafts and leisure activities and a belief that creativity should be at the heart of recovery focused services. This work is impacting on our working practices in a variety of ways and on people's lives, increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving the quality of people's lives. Since its launch in November 2011, Creative Minds has delivered more than 200 creative projects in partnership with over 70 community organisations. This has benefited over 4000 people across the Trust. Creative Minds won the 2014 HSJ Award for 'Compassionate Patient Care'.

Our commitment:

- To continue to set a leading example for partnership working
- To continue to develop our model for volunteering across the organisation - this will include supporting our staff to volunteer and gaining Investors in Volunteering Accreditation in 2016 (the UK quality standard for good practice in volunteer management)
- To continue to lead on and embed Creative Minds across our organisation and with our partners

How will we achieve it?

- By continuing to support the development of and where appropriate lead our regional and local partnership networks
- By continuing to embed Creative Minds activity in mainstream services
- By continuing to implement our vision for volunteering programme plan and working closely with National Association of Volunteer Service Managers (NAVSM)

How we will measure it?

- Regularly report on numbers of volunteers recruited
- Questionnaires and data collection from our staff and people who volunteer their time with us and by achieving external accreditation for Investors in Volunteering
- In partnership with Social Enterprise Support Centre (SESC) we are developing a tool to enable our partners to carry out social return on investment evaluations on Creative Minds projects
- Measure the impact Creative Minds projects are having on service user's packages of care

4. Finance

We are committed to embedding sustainability commitments into our financial mechanisms and to identify and develop opportunities for financial efficiencies arising from them

Our commitment:

- Embed sustainability in our financial mechanisms and Business Planning Framework
- Take advantage of schemes which support investment in energy efficient initiatives
- Develop carbon literacy with finance using guidance from the Department of Health and the NHS Sustainable Development Unit

How will we achieve it?

- Monitor the organisations financial exposure to changes in the governments Carbon Reduction Commitment Energy Efficiency Scheme (CRC-EES), improve monitoring via implementation of improved electronic systems and reporting tools
- Ensure sustainable development is managed in line with financial commitments and policy

- Regularly review the financial aspects of the Trusts carbon management projects and provide financial input to maximise carbon and energy performance

How will we measure it?

- Include quarterly carbon reduction/sustainability reporting into regular reports through Energy Manager software

5. Governance and reporting

Automated metering and monitoring will play a critical role in allowing us to monitor real time energy consumption and eradicate estimated billing, and further allow us to react early to any potential utility wastage thereby contributing to maintaining our organisations sustainability commitments. We will also utilise a number of schemes and UK accredited organisations to help us to monitoring our sustainable aspects and impacts, including:

- The Sustainable Development Unit
- BREEAM (Healthcare)
- ERIC Returns (Estates Return Information Collection)
- Good corporate citizen model

The detailed action plans for each of our commitments will be driven and monitored by the Sustainability Project Group, who report to the Sustainability Project Board which is chaired by the Director of Corporate Development.

Regular progress reports will be provided to the Executive management team and Trust Board. Public accountability for progress on actions and against this strategy will be reported through the Annual Report.

6. Conclusion

This Strategy provides a vision of why sustainable development is vital to the Trust's reputation for a range of economic and social reasons. Government targets and associated penalties put pressure on organisations to reduce carbon emissions; risks of not taking action are clear. However there are many additional reasons why a values driven socially responsible organisation should want to take action.

'Relevant today, ready for tomorrow'

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 8.1(vi)

Title:	**Medical appraisal/revalidation annual report 2014-15**
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 as required by NHS England.
Mission/values:	Ensuring that all medical staff are fit to practice and up to date supports the Trust's mission to enable people to reach their potential and live well in the community.
Any background papers/ previously considered by:	Not applicable
Executive summary:	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. 142 doctors had a prescribed connection with the Trust as at 31st March 2015. Of these, 125 had successfully completed the appraisal process during 2014/15. Seventeen doctors had an agreed postponement in line with the medical appraisal policy. These were approved by either the AMD for Revalidation or Responsible Officer as appropriate. There were 52 revalidation recommendations required from 1st April 2014 to 31st March 2015, all of which were completed on time. Forty-six doctors had positive recommendation made and the remaining 6 doctors had a recommendation of deferral. The deferrals were recommended after the Responsible Officer had consulted with the GMC Liaison Employment Advisor and the longest deferral period recommended was 12 months. All recommendations made were up held by the GMC. The implementation of the appraisal and revalidation system has been at a cost to the Trust and there are continuing requirements from NHS England to further strengthen a Trust's system and ensure the quality assurance of their processes. This may incur further financial pressures on the Trust. It has not been possible to quantify the potential cost of a doctor in difficulty and the associated costs of remediation as individual remediation will be tailored to the doctors needs. Monitoring of remediation will be undertaken by the Responding to Concerns Advisory Group. Over the course of recent years the Trust has provided Responsible Officer functions to Barnsley Hospice. This is an area of ongoing development in order to ensure a robust governance framework and the agreement of a more detailed Service Level Agreement. There is increasing expectation from the General Medical Council in terms of the quality and content of the appraisal and revalidation process and it is anticipated that this may require additional resource in due course.

Recommendation:	**Trust Board is asked to NOTE 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 2014-15

1. Executive Summary

142 doctors had a prescribed connection with the Trust as at 31st March 2015. Of these, 125 had successfully completed the appraisal process during 2014/15. Seventeen doctors had an agreed postponement in line with the medical appraisal policy. These were approved by either the AMD for Revalidation or Responsible Officer as appropriate.

There were 52 revalidation recommendations required from 1st April 2014 to 31st March 2015, all of which were completed on time. Forty-six doctors had positive recommendation made and the remaining 6 doctors had a recommendation of deferral. The deferrals were recommended after the Responsible Officer had consulted with the GMC Liaison Employment Advisor and the longest deferral period recommended was 12 months. All recommendations made were up held by the GMC.

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. 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.

4. Governance Arrangements

4.1. Trust's Revalidation Team

- Responsible Officer – Dr Nisreen Booya until 31st August 2014, Dr Adrian Berry thereafter

- 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

4.2. Policy and Guidance Update

Two policies were approved By Executive Management Team during 1st April 2014 to 31st March 2015 - version 3 of the Medical Appraisal Policy was approved in July 2014 and included a non-participation in appraisal procedure. Version 1 of the Responding to Concerns and Remediation Policy for Medical Staff was approved in January 2015.

5. Medical Appraisal

5.1. Appraisal and Revalidation Data

- Number of doctors as at 31st March 2015 who have a prescribed connection to the Trust:
  Consultants - 87 (3 of which are fixed term)
  SAS and Trust Grades - 55 (4 of which are fixed term)

- Number of completed appraisals:
  Consultants - 78
  SAS and Trust Grades - 47

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

- Number of doctors in disciplinary processes:
  Consultants - 0
  SAS and Trust Grades – 1

5.2. Appraisers as at 31st March 2015

- Number of appraisers – 29
  3 new appraisers were appointed following a formal recruitment process (as outlined it the Medical Appraisal Policy) during 2014/15 and will commence undertaking appraisals once they have attended the necessary training session. 3 of the existing appraisers will be relinquishing the role from 1st April 2015.

- Support activities undertaken:
  - Full day appraiser training was provided on 30th April and 8th May 2014. 25 of the 26 appraisers attended one or the other of the sessions. Both sessions where facilitated by Ms Alys Harwood from RES Consortium.
  - One of the new appraisers participated in the New Appraisers Training Session on 4th April 2014 which was facilitated by Dr Douglas Fraser, AMD for Revalidation from Leeds & York

Partnerships NHS FT. The remaining 2 new appraisers undertook a New Appraisers Training Session on 10th September which was facilitated by Dr Mark Radcliffe, Dr Isaura Gairin and Dr Ruth Stockill, all experienced appraisers within the Trust. Dr Radcliffe has undertaken the Train the Trainer Medical Appraiser course which was provided by the then national Revalidation Support Team.

- Appraisers Forums were held 2nd July 2014, 5th November 2014 and 27th February 2015. These continue to provide an opportunity for appraisers to share good practice and discuss areas of concern/difficulty. Continuous improvement of the appraisal process in the Trust is also an important topic for discussion the in the Forums.

5.3. Quality Assurance Processes

- The Associate Medical Director for Revalidation continues to read 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.
- On appointment of the new Responsible Officer from 1st October 2014, he also reviews every appraisal on receiving the AMD's recommendation and either concurs or requests further clarification.
- 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.
- The appraisers receive further group feedback during Appraiser Forum meetings.

5.4. Access, security and confidentiality

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

5.5. Clinical Governance

- All doctors are provided with a locked PDF record of their Incidents, Complaints, Sickness and Training from the Revalidation 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.

6. Revalidation Recommendations (1.4.14 to 31.3.15)

6.1. Number of recommendations - 52
6.2. Recommendation completed on time - 52
6.3. Positive recommendations - 46
6.4. Deferral requests - 6
6.5. Non engagement notifications - 0

7. 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. This forms part of the conditional offer of employment.

8. Monitoring Performance

The performance of all doctors 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. Information in relation to whether a doctor is involved in serious untoward incidents or subject to complaint is also included in the appraisal system. 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.

9. Responding to Concerns and Remediation

A Responding to Concerns Advisory Group, which meets monthly, 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. Remediation is carried out on an individual basis.

10. Risk and Issues

The implementation of the appraisal and revalidation system has been at a cost to the Trust and there are continuing requirements from NHS England to further strengthen a Trust's system and ensure the quality assurance of their processes. This may incur further financial pressures on the Trust.

It has not been possible to quantify the potential cost of a doctor in difficulty and the associated costs of remediation as individual remediation will be tailored to the doctors needs. Monitoring of remediation will be undertaken by the Responding to Concerns Advisory Group.

Over the course of recent years the Trust has provided Responsible Officer functions to Barnsley Hospice. This is currently being reviewed with the intention of agreeing a more detailed and robust Service Level Agreement for ongoing provision.

11. Board Reflections

Appraisal continues to develop positively. It is the subjective impression of those reviewing appraisals that there has been greater engagement in the process and greater engagement in quality improvement activities on a day to day basis.

It is believed believe that the quality improvement mechanisms are robust and stand comparison with other organisations.

The Responding to Concerns Advisory Group is now established and contributes to patient safety.

12. Corrective Actions, Improvement Plan and Next Steps

- Review the non participation in appraisal procedure to extend it scope from its current focus on timescales to take account of the content of the appraisal.
- The standard of appraisal will be continued to be developed in the appraisers forum.
- Review the need to 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.

13. 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	0
Prolonged Leave during the majority of the appraisal period	0
Suspension during the majority of the appraisal period	0
New starter	15
Postponed due to incomplete portfolio / insufficient supporting information	1
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factor (describe)	
APPRAISER FACTORS	**NUMBER**
Unplanned absence of appraiser	0
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 - 142		
	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	142	140
Is continuing professional development compliant with GMC requirements?	142	142
Is quality improvement activity compliant with GMC requirements?	142	142
Has a patient feedback exercise been completed?	142	140
Has a colleague feedback exercise been completed?	142	138
Have all complaints been included?	142	141
Have all significant events been included?	142	139
Is there sufficient supporting information from all the doctor's roles and places of work?	142	137
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	142	133
APPRAISAL OUTPUTS		
Appraisal summary	142	
Appraiser statement	142	
PDP	142	141

With the exception of one doctor, all of these deficits have been addressed satisfactorily, with 4 being agreed to address in their next appraisal.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2014 to 31 March 2015)

Recommendations completed on time (within GMC recommendation window)	52
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	52
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)		1	1	2
Conduct concerns (as primary category)		1	1	2
Health concerns (as primary category)		1		1
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.14 and 31.3.15)				1
Number of doctors who have had local restrictions placed on their practice in the last 12 months				2
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.14 and 31.3.15				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.14 and 31.3.15				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.14 and 31.3.15				1
Number of doctors who had their registration / licence suspended by the GMC between 1.4.14 and 31.3.15				0
Number of doctors who were erased from the GMC register between 1.4.14 and 31.3.15				0
NATIONAL CLINICAL ASSESSMENT SERVICES ACTIONS				
Number of doctors about whom NCAS has been contacted between 1.4.14 and 31.3.15				1
Reason for contacts:				
For advice				1
For investigation				0
For assessment				0
Number of NCAS investigations performed				0
Number of NCAS assessments performed				0

APPENDIX 5

AUDIT OF RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

NEW DOCTORS COMMENCING BETWEEN 1.4.14 and 31.3.15	NUMBER
Permanent employed doctors	5
Temporary employed doctors	7
Locums brought in to the Trust through a locum agency	50
Locums brought in to the Trust through a 'Staff Bank' arrangements	0
Other (provide explanatory note)	0
TOTAL	**62**

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[1]	Reference from last RO[1]	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs[2]	Unresolved performance concerns
Permanent employed	5	5	5	5	5	5	5	4	5	5	5	5	5	2	N/A
Temporary employed	7	7	7	7	7	7	2	2	7	7	7	7	7	1	N/A
Locums via locum agency	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**
TOTAL	12	12	12	12	12	12	7	6	12	12	12	12	12	3	

[1]Not available for those doctors joining the Trust from overseas

[2] Not available for those doctors joining the Trust from a training post or joining the Trust from overseas

** The pre employment checks for agency locums are undertaken by the agency as their employment is with them

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 A Berry

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 2015 there are 29 appraisers for 142 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 (3 during 2014-15), 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, as specified within the Trust's Responding to Concerns and Remediation 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, there is a requirement through the appraisal process that supporting information regarding a doctors full scope of practice in incorporated and reviewed.

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, an action plan is in place to continue to development the 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

Quality Performance Report

Strategic Overview

May 2015

Table of Contents

Introduction

Dear Board Member/Reader

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

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

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

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

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

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

Strategic Overview Dashboard 2015/16

Business Strategic Performance Impact & Delivery

Section	KPI	Source	Target	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 4 14/15	Apr-15	May-15	Jun-15	QTD	Year End Forecast
Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green				4
	Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4				4
CQC	CQC Quality Regulations (compliance breach)	CQC	Green	Green	Green	Green	Green	Green				4
CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*				3
	CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*				3
	CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*				3
	CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*				3
	CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*				3
IAPT	IAPT Kirklees: % Who Moved to Recovery	C	52%	***41.48%***	***49.21%***	***55.15%***	***54.17%***	64.03%	57.78%		60.95%	4
	IAPT Outcomes - Barnsley	C (FP)	90%	***97.42%***	***99.00%***	***98.02%***	***98.96%***	99.24%				4
	IAPT Outcomes - Calderdale	C (FP)	90%	***96.00%***	***78.79%***	***100%***	***94.29%***	95.12%				4
	IAPT Outcomes - Kirklees	C (FP)	90%	***95.81%***	***95.75%***	***97.24%***	***100%***	99.35%				4
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	8	0	2	0	0					4
C-Diff	C Diff avoidable cases	C	0	0	0	0	0					4
PSA Outcomes	% SU on CPA in Employment	L	10%	6.60%	7.47%	7.47%	7.43%	7.23%	7.27%		7.23%	3
	% SU on CPA in Settled Accommodation	L	60%	72.20%	70.66%	66.91%	66.08%	65.82%	63.66%		65.82%	4

Customer Focus

Section	KPI	Source	Target	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 4 14/15	Apr-15	May-15	Jun-15	QTD	Year End Forecast
Complaints	% Complaints with Staff Attitude as an Issue	L	< 25%	***13% (8/61)***	13% 23/180	15%24/160	18%29/159	12% 8/66	14% 6/44		14% 14/110	4
MAV	Physical Violence - Against Patient by Patient	L	14-20	***Above ER***	***Above ER***	***Above ER***	***Above ER***	Above ER				4
	Physical Violence - Against Staff by Patient	L	50-64	***Above ER***	***Within ER***	***Above ER***	***Above ER***	Above ER				4
FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100%	100%	100%	100%	100% 24/24	100% 17/17		100% 41/41	4
Media	% of Positive Media Coverage Relating to the Trust and its Services	L	60%	83.00%	73.00%	75.00%	92.00%	92.00%	92.00%			4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	L	50%	30.00%	56.00%	50.00%	50.00%	50.00%	50.00%			4
	% of Quorate Council Meetings	L	100%	100%	100%	100%	100%	100%	100%			4
Membership	% of Population Served Recruited as Members of the Trust	M	1%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%			4
	% of 'Active' Members Engaged in Trust Initiatives	M	50%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%			4
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	L	70%	75.00%	80.00%	50.00%	50.00%	50.00%	50.00%			4
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	88.00%	80.00%	80.00%	100.00%	100.00%	100.00%			4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%			4

Strategic Overview Dashboard 2015/16

Operational Effectiveness: Process Effectiveness

Section	KPI	Source	Target	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 4 14/15	Apr-15	May-15	Jun-15	QTD	Year End Forecast
Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	99.10%	98.92%	99.33%	99.49%	99.11%	100%		99.11%	4
	Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	98.50%	97.31%	97.95%	98.25%	98.06%	97.09%		98.06%	4
	Delayed Transfers Of Care (DTOC) (Monitor)	M	7.50%	4.18%	4.97%	4.59%	3.20%	2.50%	1.49%		2.50%	4
	% Admissions Gatekept by CRS Teams (Monitor)	M	95%	96.50%	95.06%	100%	100%	*98.39%*			98.39%	4
	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	M	95%	96.84%	95.36%	96.33%	98.41%	98.20%	100%		98.20%	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	M	95%	96.50%	98.06%	98.64%	98.59%	96.37%	95.18%		95.77%	4
	Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	186.19%	179.49%	200.84%	177.82%					4
	Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%		100%	4
	Data completeness: comm services - Referral information	M	50%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%		94%	4
	Data completeness: comm services - Treatment activity information	M	50%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%		94%	4
	Data completeness: Identifiers (mental health) (Monitor)	M	97%	99.40%	99.54%	99.58%	99.59%	99.70%	99.64%		99.67%	4
	Data completeness: Outcomes for patients on CPA (Monitor)	M	50%	84.40%	83.20%	80.04%	80.27%	78.83%	79.07%		78.95%	4
	Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant			4
Data Quality	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	L	99%	81.71%	100%	100%	99.46%	99.51%	100%		99.75%	4
	% Valid NHS Number	C (FP)	99%	99.94%	99.94%	99.65%	99.88%	99.87%				4
	% Valid Ethnic Coding	C (FP)	90%	93.34%	94.87%	95.32%	95.11%	99.05%				4
Mental Health PbR	% of eligible cases assigned a cluster	L	100%	95.90%	95.90%	95.81%	95.48%	95.30%	95.48%		95.30%	3
	% of eligible cases assigned a cluster within previous 12 months	L	100%	80.10%	79.10%	78.56%	76.64%	76.60%	77.62%		76.60%	3

Fit for the future Workplace

Section	KPI	Source	Target	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 4 14/15	Apr-15	May-15	Jun-15	QTD	Year End Forecast
Sickness	Sickness Absence Rate (YTD)	L	4%	4.50%	4.50%	4.70%	4.80%	4.80%	5.30%		5.30%	1
Vacancy	Vacancy Rate	L	10%	4.60%	4.70%							4
Appraisal	Appraisal Rate Band 6 and above	L	95%	54.10%	88.50%	95.90%	96.45%	Avail M6	Avail M6		Avail M6	4
	Appraisal Rate Band 5 and below	L	95%	17.00%	78.30%	96.30%	97.07%	Avail M3	Avail M3		Avail M3	4
Mandatory Training	Aggression Management	L	80%	56.60%	62.60%	67.30%	72.95%	73.70%	73.65%		73.65%	1
	Equality, Diversity & Inclusion	L	80%	62.30%	70.20%	74.70%	81.43%	82.30%	84.55%		84.55%	4
	Fire Safety	L	80%	76.74%	82.70%	84.30%	86.28%	86.50%	86.24%		86.24%	4
	Infection, Prevention & Control & Hand Hygiene	L	80%	63.00%	71.30%	76.70%	80.90%	80.60%	82.09%		82.09%	4
	Information Governance	M	95%	89.91%	89.80%	85.70%	96.04%	91.90%	92.55%		92.55%	4
	Safeguarding Adults	L	80%	74.20%	78.60%	78.40%	82.19%	82.80%	82.60%		82.60%	4
	Safeguarding Children	L	80%	69.70%	77.30%	81.50%	84.38%	84.70%	85.22%		85.22%	4
	Food Safety	L	80%	41.80%	48.40%	57.70%	63.66%	65.20%	66.89%		66.89%	1
	Moving & Handling	L	80%	36.10%	52.40%	62.00%	70.14%	71.80%	73.66%		73.66%	1

KEY	
4	Forecast met, no plan required/plan in place likely to deliver
3	Forecast risk not met, plan in place but unlikely to deliver
2	Forecast high risk not met, plan in place but vey unlikely to deliver
1	Forecast Not met, no plan / plan will not deliver
CQC	Care Quality Commission
M	Monitor
C	Contract
C (FP)	Contract (Financial Penalty)
L	Local (Internal Target)
ER	Expected Range
N/A	Not Applicable
Above ER	Bold Itallic means figure represents the last month in a quarter not a quarter figure

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 2 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					1	-	-
1	Monitor Risk Rating			↑			
2	£0.74m Deficit on Income & Expenditure			↑			
3	Cash Position			↓			
4	Capital Expenditure			↓			
5	Delivery of CIP			↓			
6	Better Payment Practice Code			↔			

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

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at May 2015, is a net surplus of £0.20m which is £0.67m ahead of plan.

The forecast for the year remains consistent with plan at a deficit of £0.74m

3. At May 2015 the cash position is £29.35m which is £3.15m behind plan. This is primarily due to higher than planned debtors and further progress has been made to reduce this in June 2015.

4. Capital spend to May 2015 is £1.24m which is £0.22m (15%) behind the Trust capital plan.

5. At month 2 the Cost Improvement Programme is £0.28m (21%) behind plan. Currently £2.3m (23%) of the Annual Plan has been rated as red which means there is currently low confidence in delivery.

6. As at 31st May 2015 (Month 2) 85% of NHS and 97% of non NHS invoices have achieved the 30 day payment target (95%).

Contracting

Trust Summary by BDU - Current Contract Performance

Contract Variations	
BBDU NHSE H&J: Liaison & Diversion Service - awaited	£290.2

CQUIN Performance

Quarter	Quarter 1 £000s	Achieved	Variance	Q1 Forecast based on M1 Performance	Vari
Barnsley	£371.5			£353.8	-£17.6
Wakefield	£185.7			£176.9	-£8.9
Kirklees	£206.4			£197.2	-£9.1
Calderdale	£92.6			£88.5	-£4.1
Specialised	£73.1			£73.1	£0.0
Forensics	£22.5			£22.5	£0.0
Trust Total	£951.8	£0.0	£0.0	£912.1	-£39.7

CQUIN Performance Year-end Forecast

Quarter	Annual £000s	Forecast Achievement	Variance
Barnsley	£1,795.8	£1,621.8	-£174.0
Wakefield	£793.9	£581.4	-£212.6
Kirklees	£878.2	£648.0	-£230.3
Calderdale	£394.1	£290.8	-£103.3
Specialised	£292.6	£254.8	-£37.8
Forensics	£562.3	£453.6	-£108.7
Trust Total	£4,717.0	£3,850.3	-£866.7

CQUIN Performance - see narrative on next page

CQUIN Performance Q1 Hotspots

West CCGs Improving Urgent & Emergency Care, Reduction in A&E MH reattendances Scheme still tbc with Commissioners and risk share agreed

BBDU MH Clustering - Clustering Initial Referrals

Other Contracts Performance areas

CAMHS C&K: Commissioners more assured about data quality and what is being reported.The service has received positive feedback from arranged Commissioner visits into the service.

CAMHS W:Data being pulled via RiO continues to not reflect service delivery.This is being picked-up internally. Commissioner/Service relations are extremely good.

LD:

Forensics:- National procurement identified during 2015/16 Medium & LSS MH Services Joint Commissioner / Provider review of Outreach services & pathways to verify funding Joint Review of Service Unit Prices to inform future Commissioning and service delivery.

QIPP Targets & Delivery for 2015/16

CCG	Target £000s	Planned £000s	Remainder £000s	RAG
Wakefield*	£1,790.0	£1,339.5	-£450.5	
Kirklees**	£500.0	£0.0	-£500.0	
Calderdale	£0.0	£0.0	£0.0	
TOTAL £000s	£2,290.0	£1,339.5	-£950.5	

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme

Proposals under the QIPP scheme -

W:- £1.79m in total. OOA Bed Mgt - above plan: OPS Reconfiguration (Savile Park): MH Contract reduction - delivered: OAPs for LD & CHC (CCG held budgets)- high risk: Castle Lodge (CCG budget) - delivered: Repricing LD beds - nearly complete:

C:- 15/16 Schemes to be identified by end of Q1

K:- £1m in total: 1) Reduction on OOA spend for Specialist Rehabilitation & Recovery placements £500k, 2) Reduction in OOA LD Specialist placements £500k (CCG budgets), both schemes required to generate in excess of £1m, for reinvestment in new service models

KPIs and Penalties

Commissioner	Penalty £000s	Comment
Barnsley CCG	£10.0	MSK month 1

Contract Performance Information - based on month 1

Key areas where performance is above contracted levels

· Acute MH Inpatient services for adults of working age across W,K,C BDUs
· MH PICU Inpatient services for adullts of working age in Calderdale
· Older People's MH inpatients services in Wakefield
· Older People's Memory services across W &K
· Intermediate Care in Barnsley

Key areas where performance is below contracted levels

· MH PICU Inpatient services for adullts of working age in W & K
· MH Adult Crisis Resolution services in Wakefield
· MH Adult Rehabilitation services in Wakefield & Calderdale
· Diabetes nursing and MSK in Barnsley

Key areas where performance is back on target

· IAPT: Kirklees - remains above 52% target

Health and Well Being Contracts Performance Issues

Both Sheffield & Barnsley Stop Smoking will have to reduce costs due to the reduction in funding in the revised contracts

Mental Health Currency Development

The Trust continues to work with other organisations to develop National Currencies and Local Tariffs for Mental Health.

The currency for most mental health services for working age adults and older people has been defined as the 'clusters'. That means that service users have to be assessed and allocated to a cluster by their mental health provider, and that this assessment must be regularly reviewed in line with the timing and protocols. Cluster data can be used to support the measurement of quality of service and outcomes.

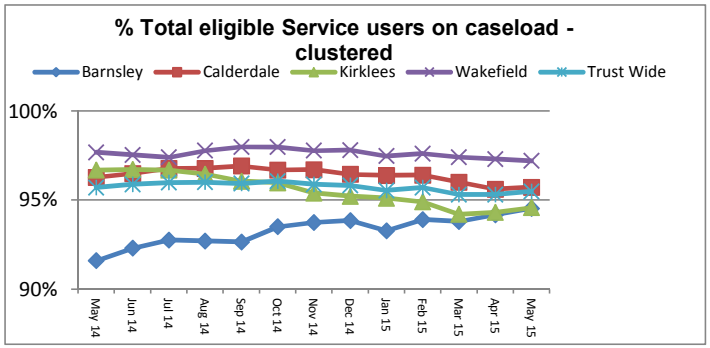
The scope of clustering is now being extended into other areas of Mental Health such as Learning Disabilities, Forensic, IAPT and Children and Adolescent Mental Health Services.

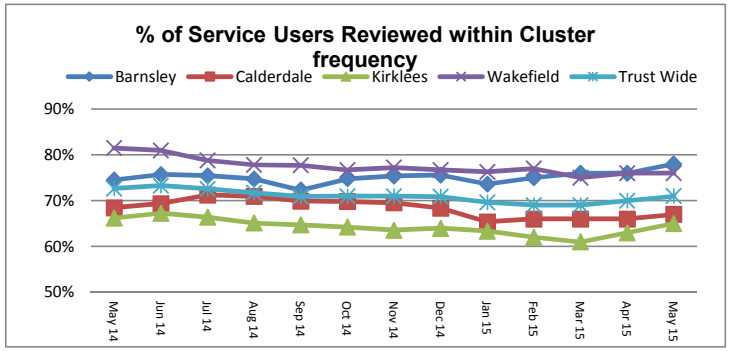
The Trust have been successful in agreeing a CQUIN related to MH Clustering in the two main commissioning contracts and this will assist greatly in the data quality preparatory work that needs to be undertaken in advance of April 2016.

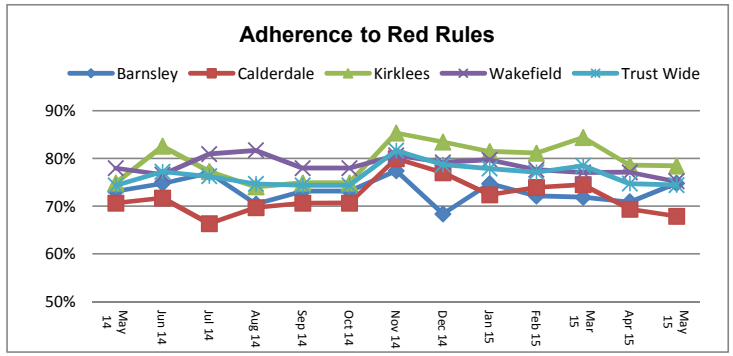
The CQUINs have 3 common elements:
Clustering of Initial Referral Assessments - 98% to be clustered within 8 weeks of 'eligible' initial referral assessments
Review of Service Users and Clusters - agreed % to be reviewed by March 2016.
Adherence to Red Rules (assurance that the cluster is accurate, complete and of high quality)
The West contract includes the development of a PbR Dashboard and this will be an interactive reporting tool. Developments are on track and April requirements have been met.

As part of the Mental Health Transformation work stream, the clusters and care packages are being used to feed into demand and capacity modelling.

MH Currency Indicators - May 2015







IAPT & Forensic Secure Services and Clustering

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

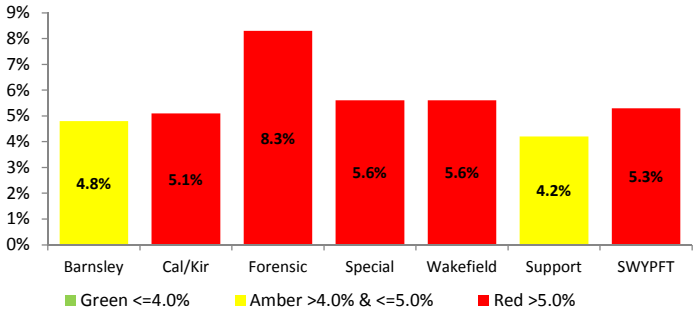
Learning Disabilities

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

Workforce

Human Resources Performance Dashboard - May 2015

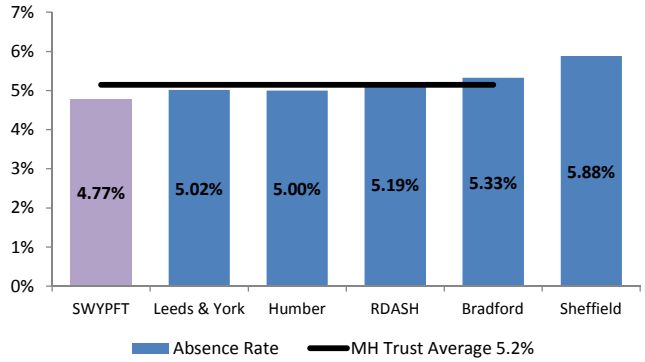
Sickness Absence



Current Absence Position - April 2015

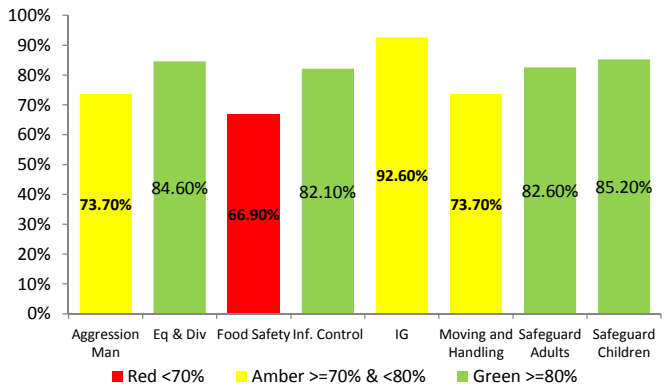
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.8%	5.1%	8.3%	5.6%	5.6%	4.2%	5.3%
Trend	↓	↓	↑	↓	↓	↓	↓

The Trust YTD absence levels in April 2015 (chart above) were above the 4% target at 5.3%



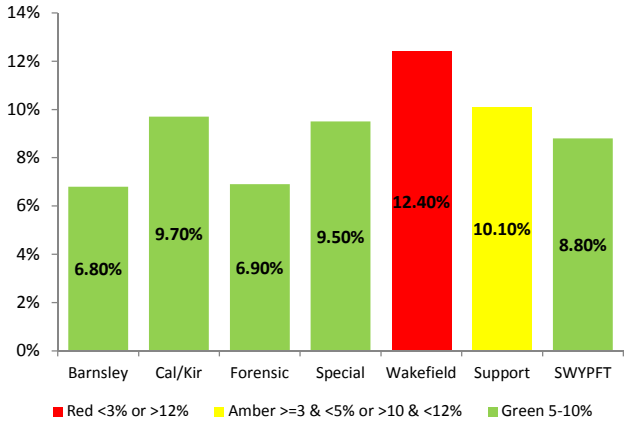
The above chart shows absence levels in MH/LD Trusts in our region to the end of Q3 2014/15. During this time the Trust's absence rate was 4.8% which is below the regional average of 5.2%.

Mandatory Training



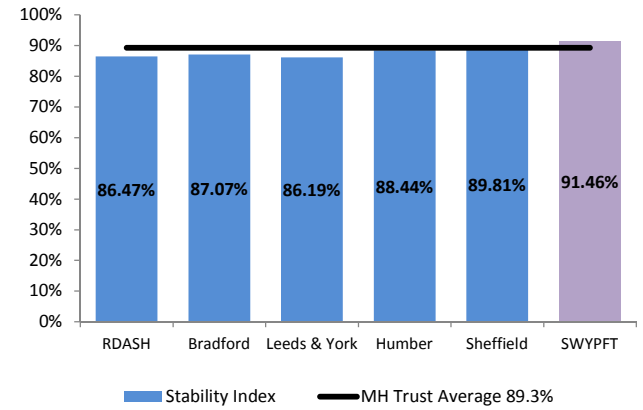
The above chart shows the mandatory training rates for the Trust. Apart from Information Governance (IG), mandatory training has a target of above 80%; IG has a target of above 95%; all are based on a rolling year.
All training rates have shown a continuous improvement over the last months.

Turnover and Stability Rate Benchmark



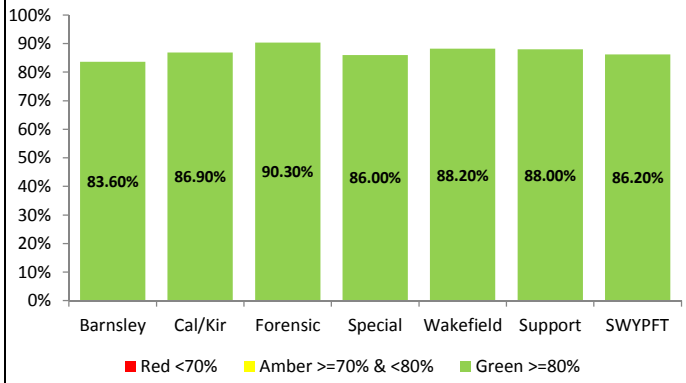
This chart shows Turnover levels up to the end of May 2015.

Turnover figures may look high but this due to the small amount of data, the above figures will level out over the new reporting year.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in Jan 2015. The stability rate shows the percentage of staff employed with over a years' service. It shows that the Trust has the best stability rate compared with other MH/LD Trusts in our region.

Fire Lecture Attendance



The Trust continues to achieve its 80% target for fire lecture training, with all areas having maintained their figures above target for several months.

Workforce - Performance Wall

Trust Performance Wall

Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	4.6%	4.7%	4.8%	4.8%	4.8%	5.3%
Sickness (Monthly)	<=4%	5.1%	5.3%	5.4%	5.0%	5.3%	5.6%
Appraisals (Band 6 and above)	>=95%	95.9%	96.2%	96.5%	96.5%	4.0%	13.1%
Appraisals (Band 5 and below)	>=95%	96.3%	96.9%	97.0%	97.1%	2.7%	5.4%
Aggression Management	>=80%	67.3%	68.6%	70.9%	72.9%	73.7%	73.7%
Equality and Diversity	>=80%	74.7%	77.0%	78.9%	81.4%	82.3%	84.5%
Fire Safety	>=80%	84.3%	84.1%	85.0%	86.3%	86.5%	86.2%
Food Safety	>=80%	57.7%	58.0%	62.4%	63.7%	65.2%	66.9%
Infection Control and Hand Hygiene	>=80%	76.7%	77.1%	78.7%	80.9%	80.6%	82.1%
Information Governance	>=95%	85.7%	83.8%	86.1%	96.0%	91.9%	92.6%
Moving and Handling	>=80%	62.0%	65.0%	67.4%	70.1%	71.8%	73.7%
Safeguarding Adults	>=80%	78.4%	79.5%	81.0%	82.2%	82.8%	82.6%
Safeguarding Children	>=80%	81.5%	82.5%	83.4%	84.4%	84.7%	85.2%
Bank Cost		£320k	£334k	£363k	£502k	£412k	£360k
Agency Cost		£358k	£269k	£383k	£517k	£296k	£720k
Overtime Cost		£11k	£12k	£14k	£11k	£12k	£13k
Additional Hours Cost		£76k	£70k	£89k	£93k	£104K	£76k
Sickness Cost (Monthly)		£539k	£585k	£581k	£481k	£567k	£540k
Vacancies (Non-Medical) (WTE)		371.42	381.86	408.27	404.26	308.42	343.02
Business Miles		308k	306k	314k	310k	295k	304k

Barnsley District

Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	4.2%	4.3%	4.4%	4.4%	4.5%	4.8%
Sickness (Monthly)	<=4%	4.7%	5.1%	4.9%	5.0%	5.3%	4.9%
Appraisals (Band 6 and above)	>=95%	97.1%	96.9%	96.9%	96.7%	4.7%	18.1%
Appraisals (Band 5 and below)	>=95%	95.6%	96.5%	96.5%	96.8%	3.1%	5.8%
Aggression Management	>=80%	76.7%	74.2%	82.7%	83.7%	85.3%	79.9%
Equality and Diversity	>=80%	79.9%	81.4%	82.6%	83.8%	84.6%	86.9%
Fire Safety	>=80%	84.2%	82.8%	83.6%	83.7%	82.6%	83.6%
Food Safety	>=80%	66.2%	65.8%	69.9%	70.4%	74.4%	76.3%
Infection Control and Hand Hygiene	>=80%	81.3%	80.1%	81.3%	83.2%	82.4%	83.9%
Information Governance	>=95%	89.2%	84.1%	84.8%	93.2%	90.1%	90.2%
Moving and Handling	>=80%	65.8%	69.4%	70.8%	72.1%	73.4%	76.0%
Safeguarding Adults	>=80%	84.2%	83.8%	84.0%	85.4%	85.2%	86.1%
Safeguarding Children	>=80%	82.1%	82.7%	84.1%	84.5%	84.7%	85.1%
Bank Cost		£34k	£44k	£54k	£64k	£57K	£67k
Agency Cost		£134k	£12k	£109k	£181k	£46k	£259k
Overtime Cost		£4k	£3k	£5k	£6k	£9k	£10k
Additional Hours Cost		£37k	£33k	£46k	£48k	£56k	£43k
Sickness Cost (Monthly)		£180k	£197k	£181k	£158k	£201k	£182k
Vacancies (Non-Medical) (WTE)		118.0	119.5	119.5	122.4	110.6	120.4
Business Miles		131k	134k	138k	129k	135k	134k

Calderdale and Kirklees District

Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (Monthly)	<=4%	4.2%	4.4%	4.9%	4.8%	5.4%	5.1%
Appraisals (Band 6 and above)	>=95%	99.7%	100.0%	100.0%	100.0%	2.4%	4.7%
Appraisals (Band 5 and below)	>=95%	98.9%	98.9%	98.7%	98.4%	5.1%	7.3%
Aggression Management	>=80%	67.0%	66.9%	67.8%	71.1%	75.4%	77.9%
Equality and Diversity	>=80%	75.9%	77.3%	80.4%	82.5%	83.1%	85.0%
Fire Safety	>=80%	86.5%	87.9%	88.0%	90.4%	90.0%	86.9%
Food Safety	>=80%	42.2%	42.4%	52.8%	54.5%	58.7%	59.5%
Infection Control and Hand Hygiene	>=80%	74.4%	76.8%	78.4%	80.6%	81.2%	82.9%
Information Governance	>=95%	86.6%	90.0%	92.3%	98.7%	92.6%	94.8%
Moving and Handling	>=80%	62.8%	65.2%	66.0%	67.4%	68.8%	70.4%
Safeguarding Adults	>=80%	75.1%	78.3%	80.2%	81.0%	81.2%	79.7%
Safeguarding Children	>=80%	79.0%	80.9%	81.7%	82.0%	83.1%	84.6%
Bank Cost		£73k	£89k	£105k	£120k	£117k	£108k
Agency Cost		£68k	£59k	£40k	£83k	£59k	£157K
Overtime Cost		£4k	£7k	£6k	£3k	£1k	£0K
Additional Hours Cost		£3k	£6k	£4k	£3k	£3k	£2K
Sickness Cost (Monthly)		£94k	£105k	£105k	£99k	£113k	£101K
Vacancies (Non-Medical) (WTE)		60.12	61	89.55	89.24	75.76	79.76
Business Miles		70k	59k	61k	63k	58k	66K

Forensic Services

Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	7.1%	7.2%	7.3%	7.4%	7.4%	8.3%
Sickness (Monthly)	<=4%	8.0%	7.9%	8.4%	7.5%	7.7%	8.3%
Appraisals (Band 6 and above)	>=95%	96.2%	98.2%	98.1%	98.1%	3.1%	6.0%
Appraisals (Band 5 and below)	>=95%	92.7%	93.4%	94.1%	93.9%	1.0%	2.3%
Aggression Management	>=80%	71.9%	72.6%	74.7%	76.4%	77.6%	76.3%
Equality and Diversity	>=80%	74.7%	78.6%	84.0%	85.8%	87.7%	88.7%
Fire Safety	>=80%	86.7%	86.0%	88.5%	89.6%	91.8%	90.3%
Food Safety	>=80%	50.7%	50.3%	50.0%	51.0%	52.9%	55.8%
Infection Control and Hand Hygiene	>=80%	73.8%	77.1%	80.4%	83.2%	83.5%	84.2%
Information Governance	>=95%	88.5%	84.5%	95.7%	98.4%	94.1%	94.4%
Moving and Handling	>=80%	64.8%	68.4%	74.3%	76.6%	78.2%	79.2%
Safeguarding Adults	>=80%	73.1%	76.6%	83.9%	85.6%	86.4%	86.9%
Safeguarding Children	>=80%	76.5%	77.9%	79.4%	81.5%	83.1%	84.6%
Bank Cost		£95k	£92k	£83k	£137k	£93k	£61K
Agency Cost		£33k	£61k	£96k	£56k	£58k	£116K
Additional Hours Cost		£1k	£0k	£0k	£3k	£0k	£1K
Sickness Cost (Monthly)		£68k	£71k	£76k	£63k	£70k	£74K
Vacancies (Non-Medical) (WTE)		45.31	46.46	41.9	39.5	16.26	16.94
Business Miles		4k	4k	4k	7k	3k	4K

Workforce - Performance Wall cont…

Specialist Services							
Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	5.5%	5.5%	5.7%	5.7%	5.7%	5.6%
Sickness (Monthly)	<=4%	6.4%	5.8%	6.9%	6.0%	5.3%	5.7%
Appraisals (Band 6 and above)	>=95%	80.1%	82.2%	84.9%	84.7%	4.8%	12.7%
Appraisals (Band 5 and below)	>=95%	83.8%	86.8%	89.0%	88.8%	1.4%	3.9%
Aggression Management	>=80%	58.6%	66.3%	71.6%	74.3%	67.5%	69.3%
Equality and Diversity	>=80%	68.7%	73.4%	75.3%	82.5%	83.7%	86.7%
Fire Safety	>=80%	74.2%	76.1%	78.4%	84.0%	86.2%	86.0%
Food Safety	>=80%	79.0%	78.7%	79.3%	83.9%	70.2%	72.2%
Infection Control and Hand Hygiene	>=80%	68.6%	68.5%	72.7%	77.6%	78.6%	79.5%
Information Governance	>=95%	82.8%	79.4%	75.4%	94.8%	88.4%	89.2%
Moving and Handling	>=80%	55.5%	57.3%	60.9%	66.3%	69.6%	72.5%
Safeguarding Adults	>=80%	66.4%	70.0%	72.1%	75.1%	77.5%	78.1%
Safeguarding Children	>=80%	74.7%	76.3%	78.8%	83.4%	82.2%	81.8%
Bank Cost		£26k	£29k	£25k	£34k	£24k	£31K
Agency Cost		£96k	£114k	£69k	£152k	£92k	£145K
Overtime Cost		£2k	£1k	£2k	£2k	£2k	£2K
Additional Hours Cost		£6k	£5k	£7k	£6k	£9k	£7K
Sickness Cost (Monthly)		£70k	£69k	£84k	£62k	£58k	£60K
Vacancies (Non-Medical) (WTE)		35.92	37.5	36.48	33.44	42.31	52.51
Business Miles		32k	30k	31k	31k	29k	29K

Support Services							
Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	3.9%	4.1%	4.2%	4.2%	4.1%	4.2%
Sickness (Monthly)	<=4%	5.1%	5.4%	5.0%	3.6%	3.8%	4.2%
Appraisals (Band 6 and above)	>=95%	99.0%	100.0%	99.5%	99.5%	1.5%	9.5%
Appraisals (Band 5 and below)	>=95%	99.2%	99.4%	99.6%	99.6%	1.9%	4.0%
Aggression Management	>=80%	49.5%	51.9%	49.6%	49.2%	49.2%	51.0%
Equality and Diversity	>=80%	62.5%	65.0%	65.9%	68.6%	69.2%	72.4%
Fire Safety	>=80%	85.4%	85.1%	84.9%	88.3%	88.9%	88.0%
Food Safety	>=80%	95.4%	94.5%	96.2%	97.1%	87.7%	89.3%
Infection Control and Hand Hygiene	>=80%	74.8%	75.5%	74.9%	76.0%	76.5%	78.6%
Information Governance	>=95%	77.7%	77.7%	82.2%	97.1%	93.6%	94.8%
Moving and Handling	>=80%	57.4%	60.9%	65.0%	70.8%	72.1%	72.8%
Safeguarding Adults	>=80%	77.8%	77.9%	78.6%	81.7%	81.7%	79.7%
Safeguarding Children	>=80%	87.2%	87.7%	87.0%	88.2%	88.0%	87.6%
Bank Cost		£33k	£16k	£31k	£47k	£42k	£25K
Agency Cost		£11k	£3k	£23k	£23k	£16k	£25K
Overtime Cost		£0k	£1k	£1k	£0k	£0k	£0K
Additional Hours Cost		£17k	£14k	£19k	£20k	£21k	£17K
Sickness Cost (Monthly)		£73k	£88k	£80k	£47k	£59k	£63K
Vacancies (Non-Medical) (WTE)		38.94	45.78	47.33	49.43	21.26	26.51
Business Miles		41k	37k	42k	45k	38k	32K

Wakefield District							
Month		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Sickness (YTD)	<=4%	4.4%	4.4%	4.5%	4.5%	4.6%	5.6%
Sickness (Monthly)	<=4%	4.9%	4.8%	4.8%	4.8%	5.6%	5.7%
Appraisals (Band 6 and above)	>=95%	97.7%	97.7%	97.7%	97.7%	6.8%	19.2%
Appraisals (Band 5 and below)	>=95%	98.5%	98.5%	98.1%	98.1%	1.1%	7.6%
Aggression Management	>=80%	74.0%	75.6%	75.6%	78.8%	77.8%	77.7%
Equality and Diversity	>=80%	80.1%	82.0%	83.2%	87.0%	87.9%	89.4%
Fire Safety	>=80%	85.2%	85.5%	87.4%	83.7%	85.2%	88.2%
Food Safety	>=80%	51.4%	53.4%	58.7%	59.5%	61.5%	62.6%
Infection Control and Hand Hygiene	>=80%	78.9%	77.1%	80.5%	82.3%	79.4%	80.7%
Information Governance	>=95%	85.7%	84.6%	87.2%	98.0%	95.4%	94.0%
Moving and Handling	>=80%	59.0%	60.4%	62.8%	65.8%	68.6%	69.6%
Safeguarding Adults	>=80%	81.3%	80.2%	81.6%	77.6%	80.5%	81.0%
Safeguarding Children	>=80%	84.5%	85.4%	85.1%	85.3%	85.9%	86.5%
Bank Cost		£58k	£64k	£65k	£100k	£79k	£69K
Agency Cost		£16k	£19k	£46k	£20k	£24k	£18K
Additional Hours Cost		£11k	£12k	£12k	£12k	£15k	£6K
Sickness Cost (Monthly)		£53k	£56k	£56k	£52k	£66k	£59K
Vacancies (Non-Medical) (WTE)		34.53	37.51	34.65	33.16	43.09	48.87
Business Miles		30k	41k	37k	34k	32k	39K

Publication Summary

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

Monitor

Consultation on changes to the risk assessment framework: June 2015

This consultation proposes a number of measures to strengthen Monitor's regulatory regime so that foundation trusts live within their means and support improvements in financial efficiency across the sector. These changes will enable Monitor to take regulatory action earlier if a foundation trust is in deficit, failing to deliver its financial plan, or not providing value for money.

Click here for link

Smoking cessation in secondary care: mental health settings (The King's Fund)

This guidance and self-assessment framework for NHS mental health trusts to develop local action to reduce smoking prevalence and the use of tobacco.
Click here for link

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

Hospital activity data, March 2015
NHS foundation trust bulletin, May 2015
Seasonal flu vaccine uptake in healthcare workers in England: winter season 2014 to 2015
Direct access audiology waiting times, March 2015
Bed availability and occupancy: quarter ending March 2015
Diagnostic imaging dataset, May 2015
Staff friends and family test, Q4 2014-15
2015 local health profiles
Sentinel Stroke National Audit Programme, post-acute national audit 2015
Diagnostics waiting times and activity data, April 2015 and Q4 2014-15
Referral to treatment waiting times statistics, April 2015
NHS safety thermometer report - May 2014 to May 2015
Performance of the foundation trust sector: year ended 31 March 2015 (Monitor)

Glossary

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DTOC	Delayed Transfers of Care
DQ	Data Quality
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LD	Learning Disability

MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NICE	National Institute for Clinical Excellence
NHSE	National Health Service England
NHS TDA	National Health Service Trust Development Authority
NK	North Kirklees
OPS	Older People's Services
OOA	Out of Area
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
Sis	Serious Incidents
SK	South Kirklees
SMU	Substance Misuse Unit
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
SU	Service Users
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 2 (2015 / 2016)

Contents

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 2 Performance	Annual Forecast	Trend from last	Last 3 Months - Most recent		
Trust Targets					1	-	-
1	Monitor Risk Rating	●	●	↑	●		
2	£0.74m Deficit on Income & Expenditure	●	●	↑	●		
3	Cash Position	●	●	↓	●		
4	Capital Expenditure	●	●	↓	●		
5	Delivery of CIP	●	●	↓	●		
6	Better Payment Practice Code	●	●	⇔	●		

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

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at May 2015, is a net surplus of £0.20m which is £0.67m ahead of plan.

The forecast for the year remains consistent with plan at a deficit of £0.74m

3. At May 2015 the cash position is £29.35m which is £3.15m behind plan. This is primarily due to higher than planned debtors and further progress has been made to reduce this in June 2015.

4. Capital spend to May 2015 is £1.24m which is £0.22m (15%) behind the Trust capital plan.

5. At month 2 the Cost Improvement Programme is £0.28m (21%) behind plan. Currently £2.3m (23%) of the Annual Plan has been rated as red which means there is currently low confidence in delivery.

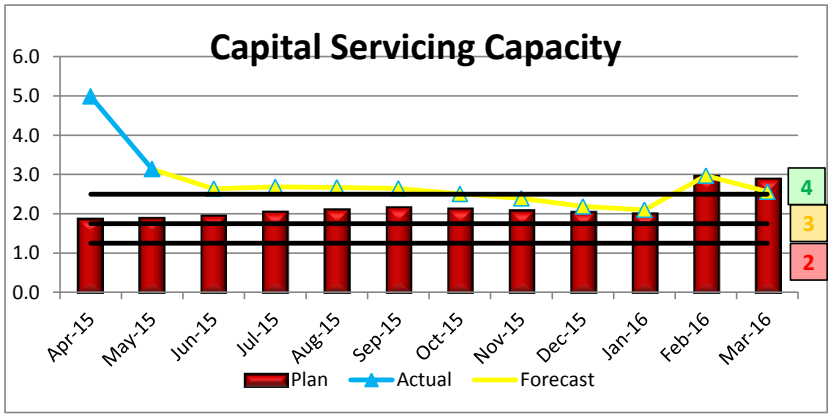
6. As at 31st May 2015 (Month 2) 85% of NHS and 97% of non NHS invoices have achieved the 30 day payment target

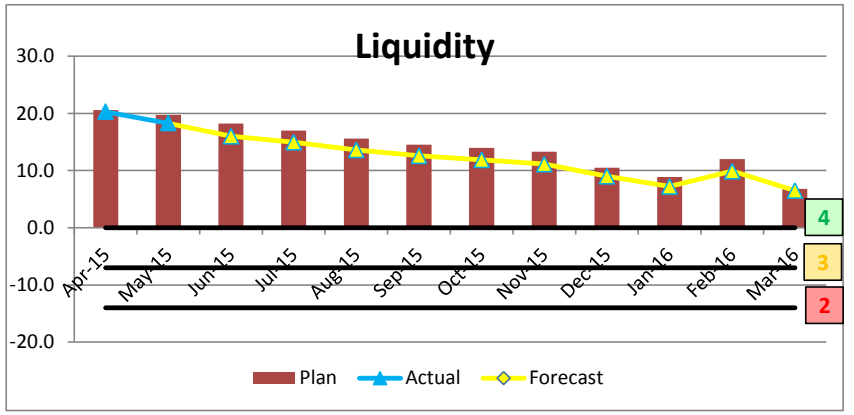
Monitor Risk Rating

Continuity of Service Risk Rating 2015 / 2016	Actual Performance		Annual Plan May 2015	
Metric	**Score**	**Rating**	**Score**	**Rating**
Capital Servicing Capacity	3.1	4	1.9	3
Liquidity	18.3	4	19.7	4
Weighted Average		4		4

Monitor are currently undertaking a consultation in regards to the Risk Assessment Framework (RAF). This proposes introducing 2 further Financial metrics

* I & E Margin - the current planned deficit would score a 2
* Variance from plan for:
    * I & E Margin
    * Capital Expenditure





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

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

Monitor - Monthly Return 2015 / 2016

During 2014 / 2015 Monitor implemented a monthly reporting data collection return for all Foundation Trusts. This was a symptom of the financial position being presented by Foundation Trusts; this cumulated in a reported deficit of £349m for all foundation Trusts during 2014 / 2015.

Foundation Trusts have communicated that 2015 / 2016 will provide further financial challenges and as such Monitor have again mandated regular monthly reporting to assist in controlling and forecasting expenditure across the system.

The current data requirements and return information are presented below. These values are consistent with the financial position included within this report and presented to Trust Board.

Additionally, Monitor are introducing further national focus upon a number of key expenditure areas:

* Management Consultancy Spend
* Agency Spend

	Plan (YTD) £m	Actual (YTD) £m	Variance (YTD) £m	Annual Plan £m	Forecast £m	Variance £m
Trusts Surplus / (Deficit) position	(0.47)	0.20	0.67	(0.74)	(0.74)	0.00
Trusts Capital Expenditure	1.46	1.24	(0.22)	12.00	12.00	0.00

Monitor Benchmarking

All Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	68	2	3	73
	3	24	9	6	39
	2	2	10	8	20
	1	0	1	16	17
	Total	94	22	33	149

Mental Health Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	29	0	1	30
	3	6	1	1	8
	2	0	2	1	3
	1				0
	Total	35	3	3	41

As at 9th March 2015 there are 152 Foundation Trusts monitored by Monitor. Of these 3 are newly authorised and as yet do not have a Risk Rating (Bradford District Care, Kent Community Health & Nottinghamshire Healthcare).

The tables to the left show that the Trust remains in the upper quadrant of this analysis with a Continuity of Service Rating of 4 and a Green Governance rating.

In April 2015 Monitor issued the Quarter 4 Performance Report for the Foundation Trust Sector. This allows us to place Trust performance in a national context. The key headlines from this were:

* NHS Overall £822m deficit, FT's £349m deficit (£339m more than planned)
* 77 FT's reported a deficit. These totalled £636m. (78 at Quarter 3)

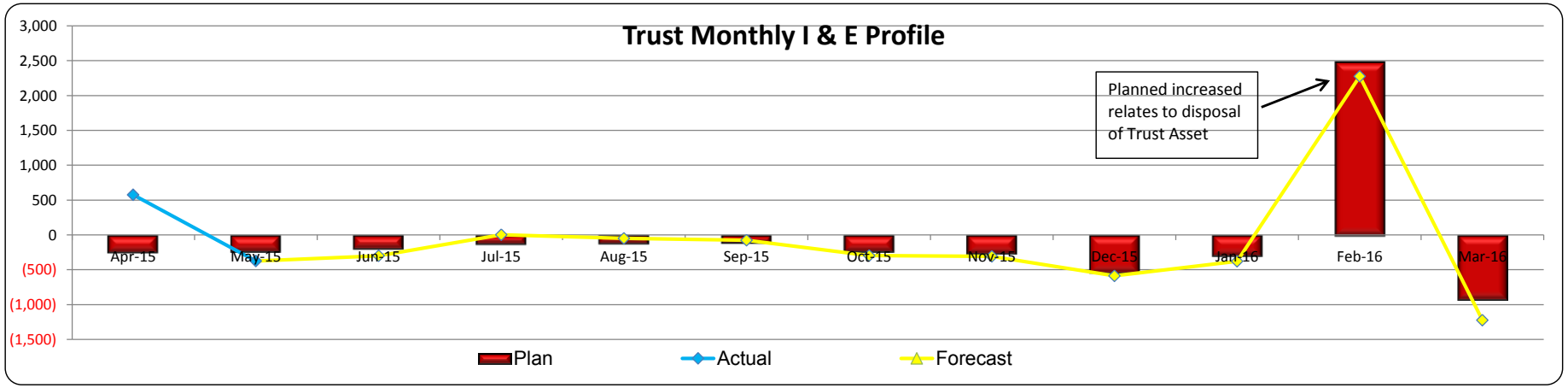
* 54 Acute Trusts in deficit - these account for 94% of the overall deficit
* 14 Mental Health Trusts reported a deficit

* Issues previously identified continued - £1bn unplanned agency spend
* £315m under delivery on CIP's

FT's have indicated that 2015 / 2016 will be even tougher.

Income & Expenditure Position 2015 / 2016

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(17,666)	(17,335)	331	Clinical Revenue	(35,459)	(35,313)	146	(210,387)	(210,132)	254
				(17,666)	**(17,335)**	**331**	**Total Clinical Revenue**	**(35,459)**	**(35,313)**	**146**	**(210,387)**	**(210,132)**	**254**
				(1,316)	(1,379)	(63)	Other Operating Revenue	(2,530)	(2,447)	82	(13,701)	(14,444)	(743)
				(18,982)	**(18,714)**	**268**	**Total Revenue**	**(37,988)**	**(37,760)**	**228**	**(224,087)**	**(224,576)**	**(489)**
4,437	4,244	(192)	4.3%	14,412	14,377	(35)	BDU Expenditure - Pay	28,720	28,341	(379)	168,265	169,301	1,035
				3,691	3,684	(6)	BDU Expenditure - Non Pay	7,422	6,939	(483)	43,691	45,338	1,647
				392	337	(55)	Provisions	884	885	1	6,985	4,828	(2,157)
4,437	**4,244**	**(192)**	**4.3%**	**18,494**	**18,398**	**(96)**	**Total Operating Expenses**	**37,025**	**36,165**	**(860)**	**218,941**	**219,466**	**525**
4,437	**4,244**	**(192)**	**4.3%**	**(488)**	**(316)**	**172**	**EBITDA**	**(963)**	**(1,595)**	**(632)**	**(5,146)**	**(5,110)**	**36**
				465	448	(17)	Depreciation	931	897	(34)	5,584	5,550	(34)
				257	257	0	PDC Paid	513	513	0	3,080	3,080	0
				(6)	(14)	(8)	Interest Received	(13)	(14)	(2)	(75)	(77)	(2)
				0	0	0	Revaluation of Assets	0	0	0	(2,700)	(2,700)	0
4,437	**4,244**	**(192)**	**4.3%**	**228**	**375**	**147**	**Deficit / (Surplus)**	**469**	**(199)**	**(668)**	**742**	**742**	**(0)**



Income & Expenditure Position 2015 / 2016

Month 2

The year to date position, as at month 2 reflects a surplus position of £0.2m which is £0.67m (143%) ahead of plan.
This is being driven by underspends within BDU operational budgets; both pay and non pay.

All pay groupings are underspending, year to date, with the exception of agency which is significantly higher than planned. This continues to be reviewed internally, both in line with Monitor reporting requirements, and in terms of ensuring that staff levels are appropriate and efficient.

The pay position overall takes account of the impact of bank, agency and locum staff.

Most areas of non pay are broadly in line with plan. The current usage of out of area beds is lower than planned Trustwide and as a result is £0.2m underspent.

Forecast

The forecast outurn position for 2015 / 2016 is a deficit position of £0.74m which is in line with plan.

However, based upon the current forecasts, provisions (£2.3m) are being utilised in order to deliver this position.

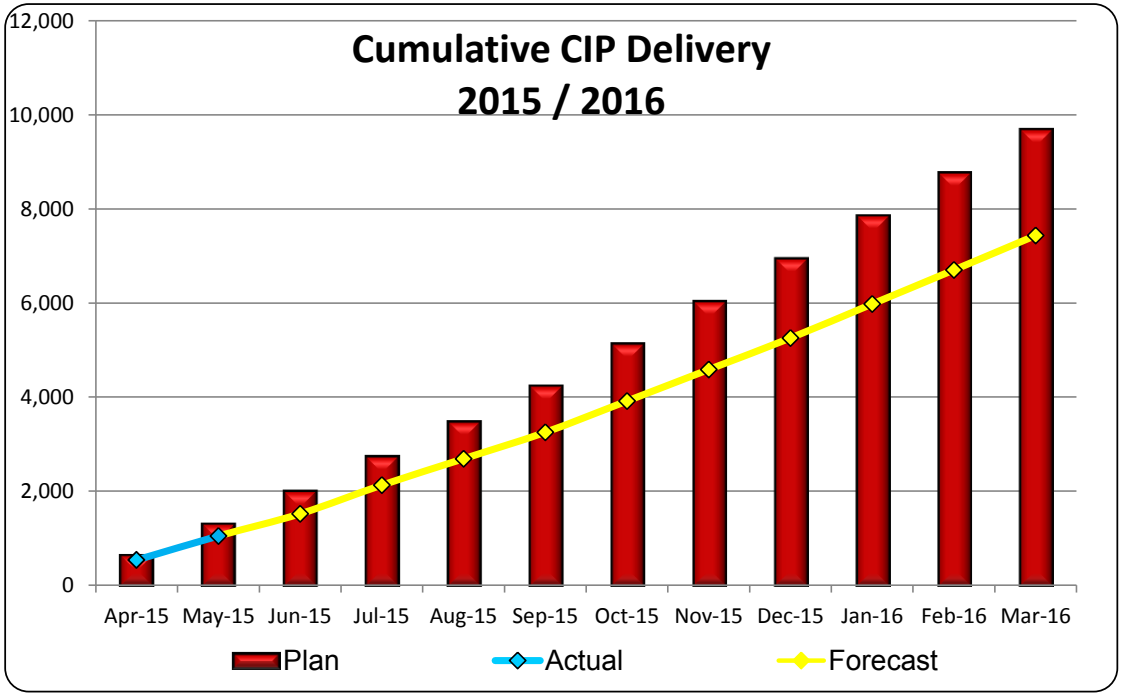
This position incorporates a number of risks; the most significant of which are:

* £2.3m Assumption that CIP's, classified as red, will not be delivered and substituted during 2015 / 2016
* £1.7m Assumption that CIP's, classified as amber, will be delivered in full during 2015 / 2016
* £2.7m That the planned disposal of a Trust Asset during 2015 / 2016 will occur and cash payment will be received.
* £0.5m The forecast position currently assumes full delivery of the Trust CQUIN target. Risk has currently been assessed as £0.5m.

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

Cost Improvement Programme 2015 / 2016

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Monitor Submission	657	664	694	738	742	756	897	902	902	909	909	917	1,322	9,687
Target - Cumulative	657	1,322	2,016	2,754	3,496	4,252	5,149	6,051	6,952	7,861	8,770	9,687	1,322	9,687
Delivery as planned	516	1,008	1,461	2,053	2,594	3,138	3,784	4,435	5,086	5,791	6,496	7,210	1,008	7,210
Mitigations - Recurrent	19	38	56	75	94	113	131	150	169	188	206	225	38	225
Mitigations - Non Recurrent	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Delivery	**535**	**1,045**	**1,517**	**2,128**	**2,688**	**3,250**	**3,915**	**4,585**	**5,255**	**5,979**	**6,702**	**7,435**	**1,045**	**7,435**
Shortfall / Unidentified	123	277	499	626	808	1,002	1,234	1,466	1,698	1,883	2,067	2,252	277	2,252



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

This position includes a current forecast shortfall of £2252k. This is reflective of schemes classified as red / risks exist in delivery less any mitigations / substitutions.

The year to date position is that, including mitigations, the Trust is £277k behind plan.

Balance Sheet 2015 / 2016

	2014 / 2015 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	106,649	107,178	106,991	1
Current Assets				
Inventories & Work in Progress	204	204	206	
NHS Trade Receivables (Debtors)	3,015	2,265	3,410	2
Other Receivables (Debtors)	4,963	4,913	8,538	2
Cash and Cash Equivalents	32,617	32,500	29,353	3
Total Current Assets	**40,799**	**39,882**	**41,508**	
Current Liabilities				
Trade Payables (Creditors)	(5,851)	(5,851)	(4,608)	4
Other Payables (Creditors)	(3,621)	(4,135)	(3,810)	4
Capital Payables (Creditors)	(770)	(770)	(1,132)	
Accruals	(10,335)	(10,035)	(11,608)	5
Deferred Income	(751)	(751)	(1,449)	
Total Current Liabilities	**(21,328)**	**(21,542)**	**(22,607)**	
Net Current Assets/Liabilities	**19,471**	**18,341**	**18,900**	
Total Assets less Current Liabilities	**126,120**	**125,519**	**125,892**	
Provisions for Liabilities	(8,104)	(7,971)	(7,676)	
Total Net Assets/(Liabilities)	**118,016**	**117,547**	**118,215**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	16,780	16,780	16,780	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,524	52,055	52,723	6
Total Taxpayers' Equity	**118,016**	**117,547**	**118,215**	

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

1. Fixed Assets are currently slightly behind plan; as noted page 11.

2. Debtors, both NHS and Non NHS are higher than planned and this is having a negative impact on the Trust cash position. Further progress is being made in June 2015 to reduce the level of debtors.

3. The reconciliation of Actual Cash Flow to Plan compares the current month end position to the Annual Plan position for the same period. This is on page 13.

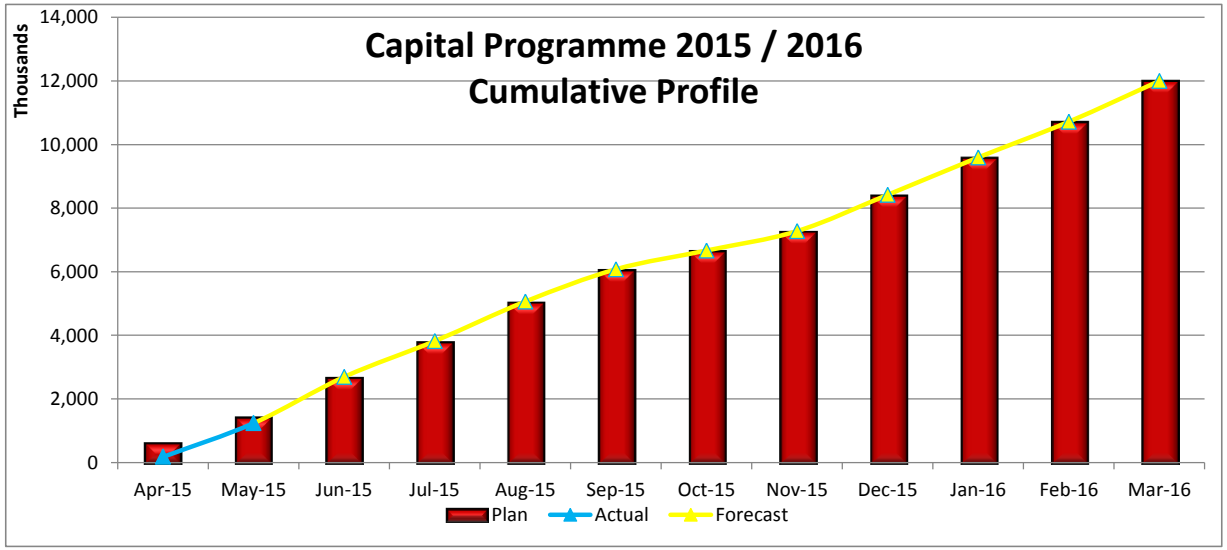
4. Creditors are lower than planned as the Trust continues to proactively pay invoices. Work continues to ensure that the Trust does not hold any old creditor values / unresolved issues.

5. Accruals are higher than planned as the Trust is still awaiting invoices. These continue to be reviewed and chased.

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

Capital Programme 2015 / 2016

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,200	105	86	(20)	2,200	0	
IM&T	2,348	37	(0)	(37)	2,348	0	
Total Minor Capital & IM &T	**4,548**	**142**	**86**	**(57)**	**4,548**	**0**	
Major Capital Schemes							
Barnsley Hub	950	267	267	(0)	950	0	3
Halifax Hub	4,052	1,050	833	(217)	4,052	0	4
Hub Development	1,450	0	42	42	1,450	0	
Fieldhead Development	1,000	0	12	12	1,000	0	
Total Major Schemes	**7,452**	**1,317**	**1,154**	**(163)**	**7,452**	**0**	
VAT Refunds	0	0	(1)	(1)	0	0	
TOTALS	**12,000**	**1,459**	**1,239**	**(221)**	**12,000**	**0**	



Capital Expenditure 2015 / 2016

1. The Trust Capital Programme for 2015 / 2016 is £12.0m and this forms part of the overall Trust Estates Strategy.

2. The year to date position is £0.22m under plan (15%). The current forecast is that expenditure will be in line with plan.

Major schemes (and progress are):

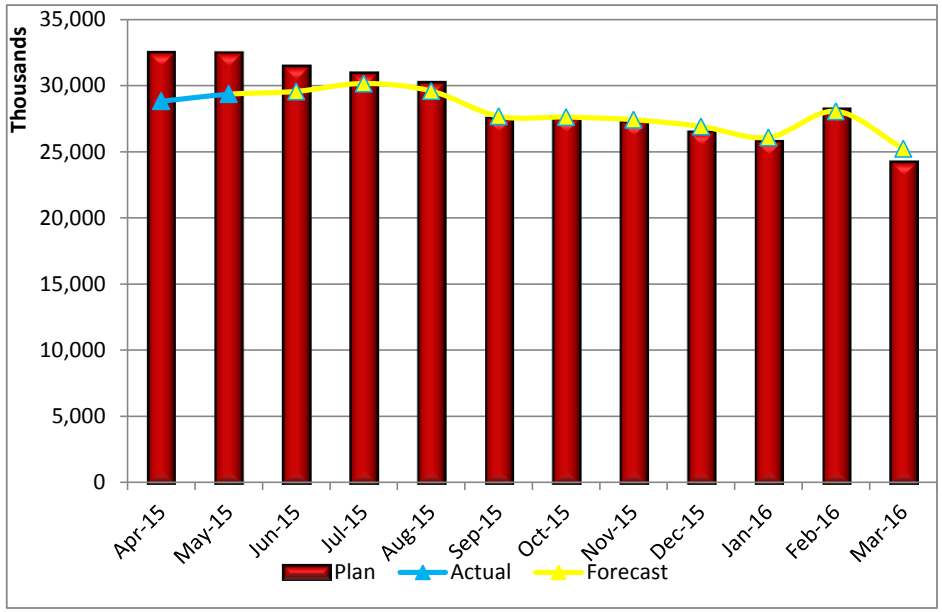
3. The scheme has moved back in line with budgetary expectations. Completion is expected in late

4. The project is coming back in line with schedule following some disruption during groundworks. Expenditure is currently behind plan; discussions continue on costs associated with the revised design. It is forecast this will be resolved in June 2015.

5. The Trust Annual Plan assumed disposal of a Trust asset during 2015 / 2016. At this time, subject to events beyond the control of the Trust, payment is still anticipated. This will continue to be monitored through Estates TAG

6. Minor Works is currently behind plan, primarily due to one scheme which has been delayed due to infection control concerns on some similar sanitary facilities. A solution is being agreed.

Cash Flow & Cash Flow Forecast 2015 / 2016



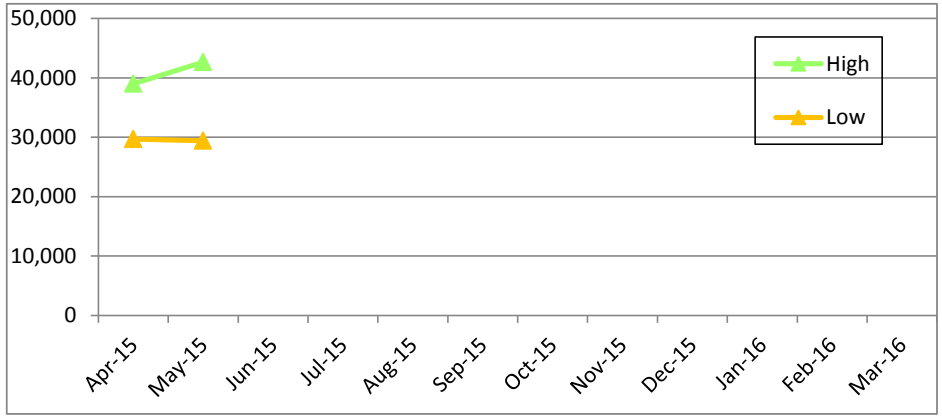
	Plan £k	Actual £k	Variance £k
Opening Balance	32,617	32,617	
Closing Balance	32,500	29,353	(3,147)

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 is £29.35m which is £3.15m under plan.

A detailed reconciliation of working capital compared to plan is presented at page 13.



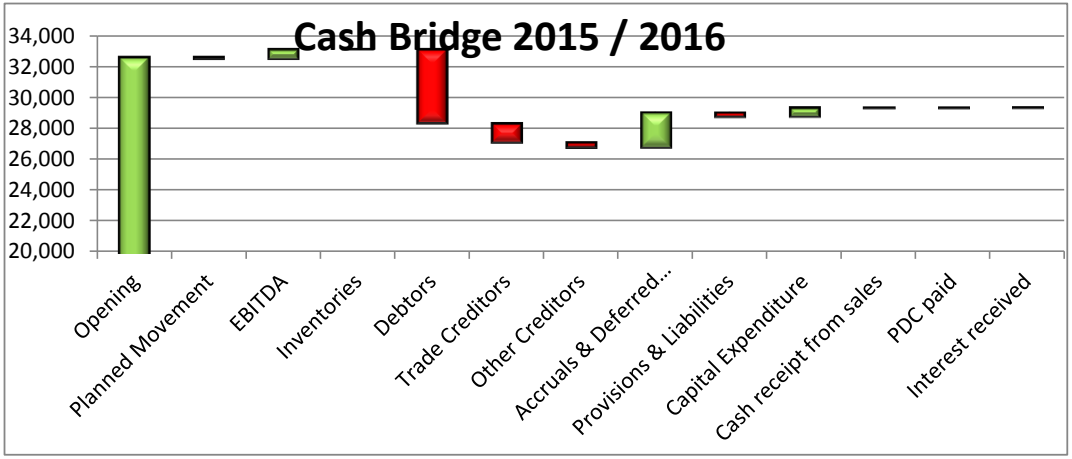
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is:	£42.64m
The lowest balance is:	£29.41m

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

Reconciliation of Cashflow to Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**32,617**	**32,617**		
Surplus (Exc. non-cash items & revaluation)	963	1,595	632	1
Movement in working capital:				
Inventories & Work in Progress	0	(2)	(2)	
Receivables (Debtors)	800	(3,970)	(4,770)	4
Trade Payables (Creditors)	0	(1,243)	(1,243)	5
Other Payables (Creditors)	0	(325)	(325)	
Accruals & Deferred income	(300)	1,971	2,271	2
Provisions & Liabilities	(133)	(428)	(295)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,459)	(876)	583	3
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Received	0		0	
Interest (paid)/ received	13	14	2	
Closing Balances	**32,500**	**29,353**	**(3,147)**	



The Plan value reflects the May 2015 submission to Monitor.

Factors which increase the cash positon against plan:

1. EBITDA, arising from the current operational I & E position, is better than planned. This is shown within the overall Trust financial position.

2. Accruals remain higher than planned; specifically the Trust is awaiting invoices in relation to April & May Service Level Agreements with other NHS organisations.

3. The capital programme is currently behind plan, and additionally, capital creditors are high as the Trust are still awaiting for invoices for work which has been completed.

Factors which decrease the cash position against plan:

4 . Debtors are higher than planned. All aged debts continue to be chased. The current issue relates to outstanding block payments for April and May 2015 with both CCG and Local Authorities. It is expected that these will all be paid in full in June 2015. (c. £3.8m)

5. Creditors are lower than planned as the Trust continues to proactively pay invoices as soon as possible.

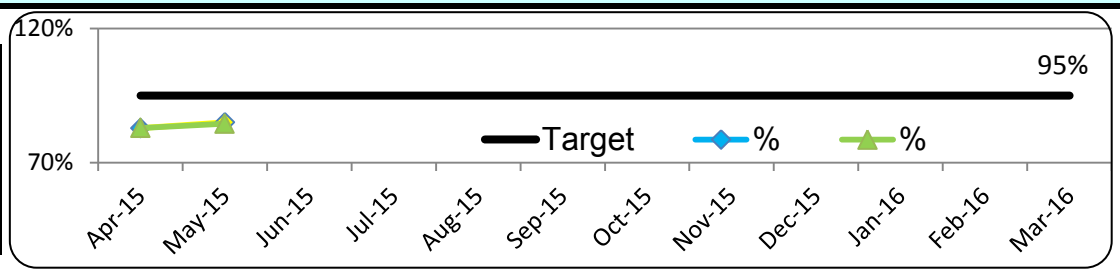
The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

Better Payment Practice Code

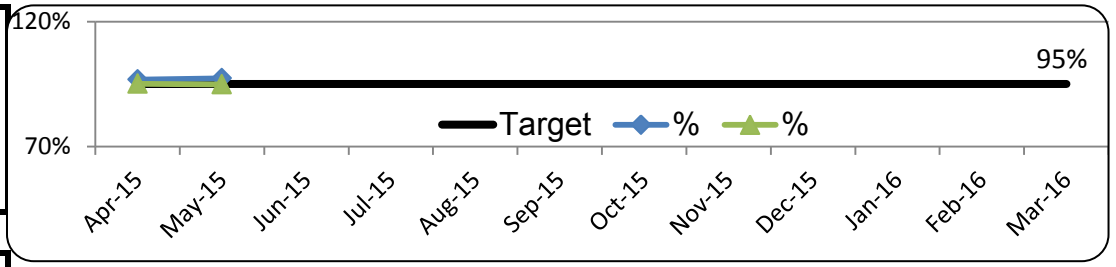
The Trust is committed to following the Better Payment Practice Code , payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.

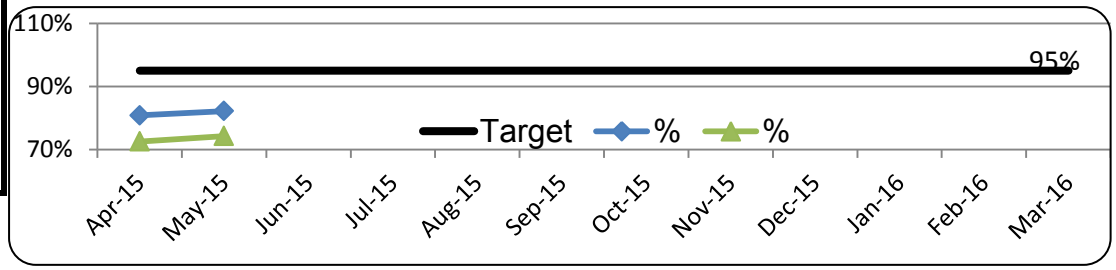
NHS	Number %	Value %
Year to April 2015	83%	83%
Year to May 2015	85%	84%



Non NHS	Number %	Value %
Year to April 2015	97%	95%
Year to May 2015	97%	95%



Local Suppliers	Number %	Value %
Year to April 2015	81%	73%
Year to May 2015	82%	74%



Transparency Disclosure

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

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

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

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

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
21/04/2015	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	2179744	81,268
30/04/2015	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2180240	56,266
13/04/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2178890	48,698
13/04/2015	Drugs	Trustwide	Lloyds Pharmacy Ltd	2178890	43,035
21/04/2015	Drugs	Trustwide	NHSBSA Prescription Pricing Division	2179744	42,793
01/05/2015	Rental	Wakefield	Wakefield MDC	8135159	30,000
30/04/2015	Staff benefits expenses	Trustwide	Childcare Vouchers Ltd	2180265	25,012

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

South West Yorkshire Partnership NHS
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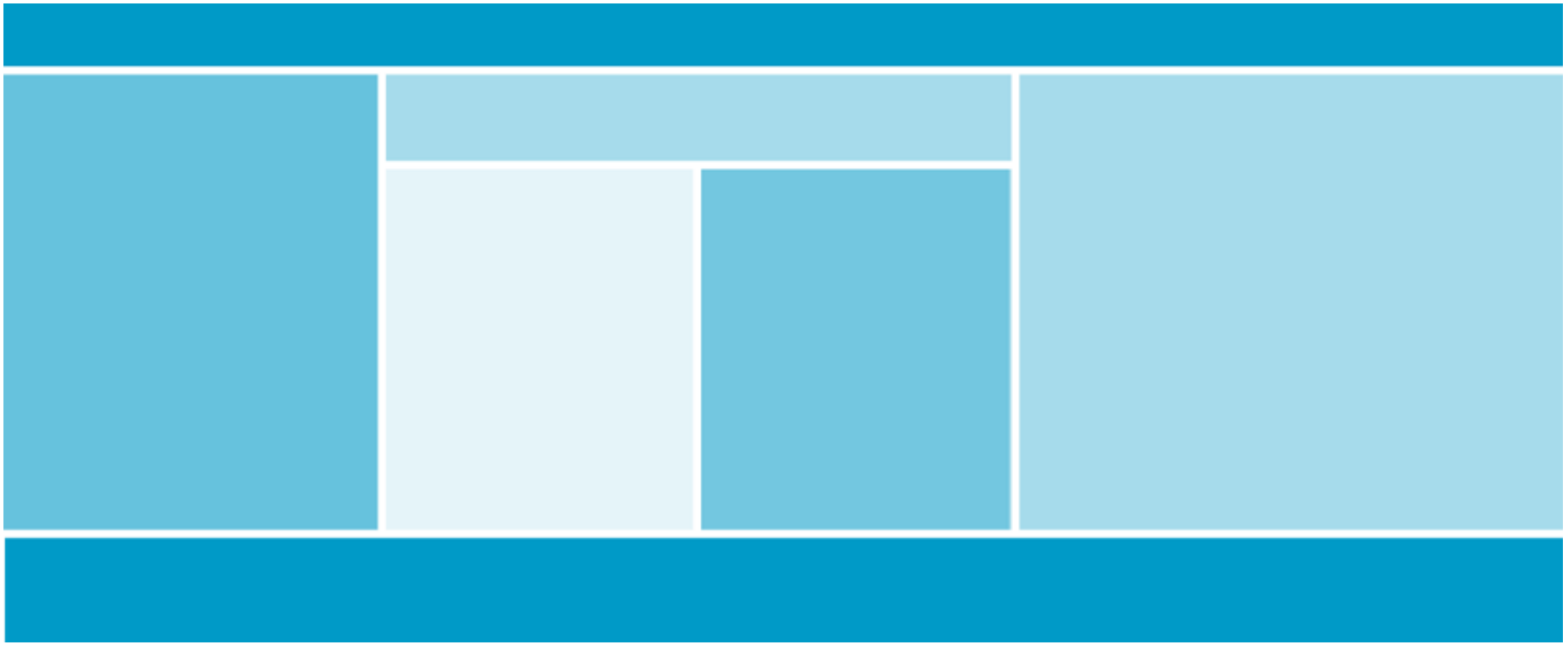
External Focus on Discretionary Spend
Trust Board – 30 June 2015



With all of us in mind

Introduction

- FT Chairs and Chief Executives received correspondence on 2 June in relation to improvement in quality, meeting access targets and driving up productivity.
- Outlined 4 initiatives.
  - Increased scrutiny of annual plans, including site visits and face-to-face meetings. (The Trust has its annual visit on 24 June 2015; however, it was arranged prior to the issue of the letter from Monitor.) After each visit an executive-led challenge session with FT boards will be held with a view to making them "more stretching". They reserve the right to use legal powers where agreement cannot be reached.
  - FTs in breach of their licence for financial reasons will be required to adopt best practice approach to spend in a number of areas. Initially this will cover spend on agency staff and management consultancy.
  - Consultation on changes to the Risk Assessment Framework (see later slides).
  - Monitor and TDA will provide support to providers and engagement in the next phase of improvement.

Agency and consultancy spend – what it means (1)

Area of spend	Expectations	Action required	Commentary	Timescales
Consultancy spend	Business case are required to be submitted and approved by Monitor for all new consultancy spend over £50,000 for those FTs in breach of their licence. Extending or varying existing contracts or incurring additional expenditure not already committed where the value exceeds £50,000. Proforma for completion provided	• Is the trust mindful to comply with these requirements? • Suggest consolidating list of existing arrangements and consider the extent to which Monitor's 'assessment criteria' has been followed. • Where expenditure exceeds £50,00 complete and submit business case for consideration and approval. • Expenditure on consultancy is market tested either via the Crown Commercial Services Consultancy One framework contract or the Trusts inTend eTendering system which publishes all tender opportunities in "Contracts Finder"	Excludes internal and external audit and local counter fraud services. £50,000 threshold includes irrecoverable VAT and expenses. These arrangements do not currently apply to contracts accounted for as capital expenditure. Consultancy is defined as in the NHS Manual for Accounts. Excludes interim management and day rate contractors.	With Immediate effect (2 June) for FTs breaching licence for financial reasons but other FTs are asked to comply voluntarily or those planning a deficit for 2015/16

Agency and consultancy spend – what it means (2)

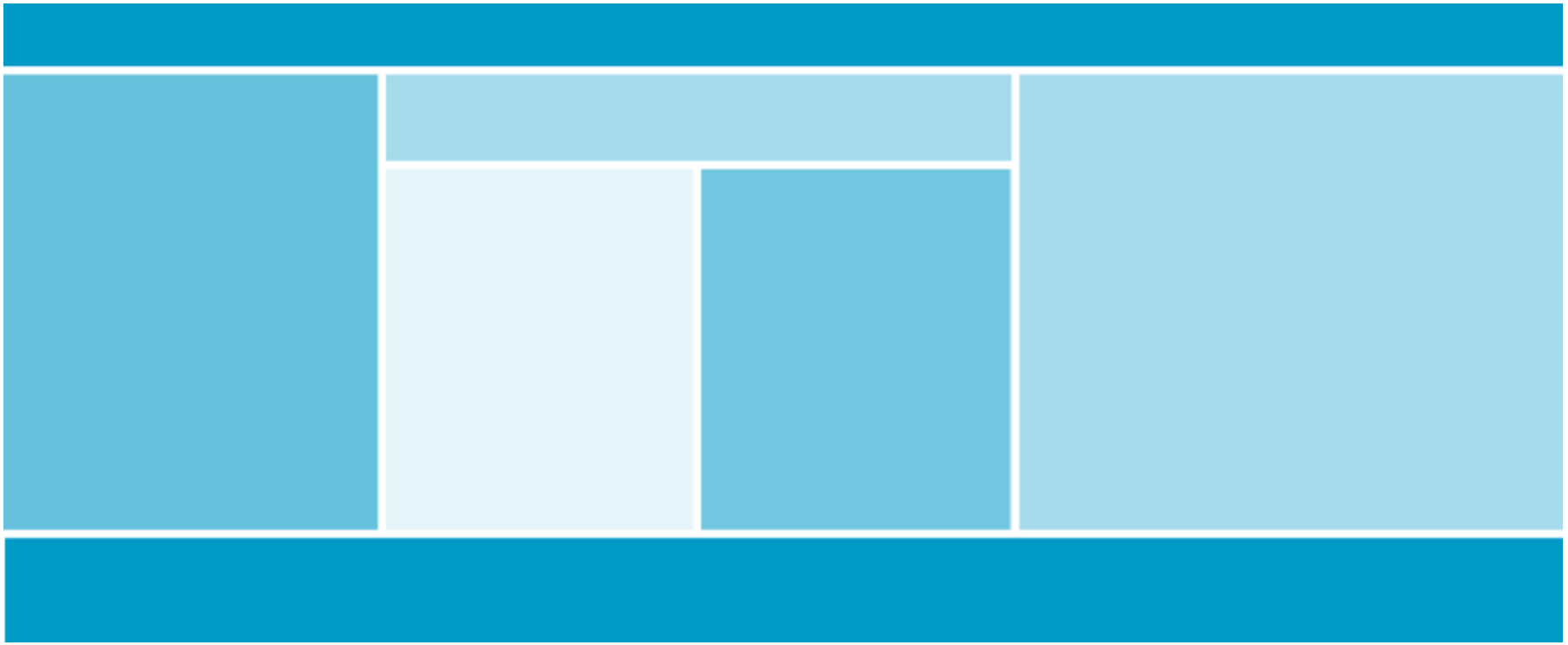
Area of spend	Expectations	Action required	Commentary	Timescales
Agency spend	Ceiling on the % of staff that can be employed on an agency basis. Cap on the maximum rates of agency pay for different types of staff. List of approved frameworks.	• Respond to the consultation • The Trust is currently trialling a Neutral Vendor for its temporary nurse provision. This business relationship has not been formalised as the Trust is waiting for the release of two Crown Commercial Services framework contracts covering the following: RM971 – Non Medical, Non Clinical Resource. RM3711 – Multi Disciplinary Temporary Healthcare Personnel (Locum Doctors, Nurses, AHP's) Both framework agreements have a workforce element (managing the Trust's internal bank), a neutral vendor option and individual agency providers. It is the Trust's intention to conduct a market testing exercise under the framework contracts to create a list of preferred suppliers and one/two neutral vendor(s). The new contract(s) will provide the Trust with a simplified process for engaging temporary staff, improved governance procedures and a cap on the rates paid which will be managed and monitored by the neutral vendor organisation	There will be mechanisms for local managers to have override to these limits in the interest of patient safety, with a retrospective review. The deadlines are exacting and will require significant organisational effort to implement. The opportunity for saving is significant given the scale of spend in 2014/15.	1 July nursing and complete implementation 1 September

Actions agreed

South West Yorkshire Partnership NHS
NHS Foundation Trust

- Assurance process to Audit Committee (7 July 2015) and Trust Board (30 June 2015).
- Brief EMT and Chair/NEDs.
- Review analysis of agency and consultancy spend in 2014/15 – rationale for expenditure and what would have been subject to a business case completed, no issues arising.
- Undertake similar exercise for off-payroll.
- Although requirement to submit business cases to Monitor doesn't apply to this Trust, internal process to be introduced from Q2 2015/16.
- EMT to approve consultancy business cases for expenditure over £50,000 and report in detail to Remuneration and Terms of Service Committee (RTSC) using Monitor template. Any spend subject to a procurement process (whether tender or quotation) will be reported to the Audit Committee.
- Business cases over £15,000 but under £50,000 within Directorate delegated limits to EMT for information and reported in outline to RTSC.
- Incorporate review of expenditure and consultancy off payroll and agency in monthly financial reporting and review use of Monitor tool.

Monitor Risk Assessment Framework consultation
Trust Board – 30 June 2015



Introduction

- As a sector, we're not doing very well (77 out of 152 trusts lost money in 2014/15). This position is unaffordable and unsustainable.
- So, Monitor is making changes to the Risk Assessment Framework (how it assesses risk to the continuity of services and the risk of poor governance) to strengthen its regulatory regime so it can help FTs live within their means and support financial efficiency across the sector.
- Consulting on the following:
  - re-introducing 2 previously used measures – one tracking deficits and another the accuracy of planning;
  - combining a trust's rating for the above with a trust's existing continuity of services rating to produce a 4-level financial sustainability and performance risk rating
  - Making two further changes to ensure trusts deliver value for money

Re-introduction of measures of FT deficits and variance from plan (1)

- I&E margin measure
  - To be calculated as a % surplus/(deficit)/total operating and non-operating income
  - Will provide a reasonable approximation of underlying performance without undue influence from one-off items or accounting adjustments

Thresholds

Rating 1 = I&E margin worse than and including (1%)

Rating 2 = Between (1%) and up to 0%]

Rating 3 = Greater than or = 0% up to 1%

Rating 4 = 1% or greater

Trust response

- I&E margin measure
  - Calculation and purpose of metric understood.
  - As Trust has planned deficit for 2015/16, Trust would score 1 on this metric (as the point is to show Trusts in deficit).

Re-introduction of measures of FT deficits and variance from plan (2)

- Additional measures of variance from plan
  - I&E margin: calculated as I&E operating surplus(deficit)/total operating income (not EBIDTA)
  - Capital expenditure: absolute variance as a % of planned capital expenditure

Thresholds

Rating	Threshold – I&E margin	Threshold – capital expenditure
Rating 1	Worse than and including (2%)	25% or higher
Rating 2	Between (2%) up to (1%)	20% and up to 25%
Rating 3	Greater than (1%) up to 0%	20% and up to 10%
Rating 4	0% or higher	10% or lower

Trust response

- Variance from plan
  - Covers both I&E and capital expenditure.
  - Formalises the information we include now within the quarterly Monitor returns into an actual metric and will affect the overall metric calculation.
  - Based on M1, we would rate 4 for I&E but 1 for capital expenditure.

NB Monitor will determine an FTs prospective ratings at the start of each financial year from achievement against the previous year's plan as a proxy.

New sustainability and financial performance risk rating

- Combine existing continuity of services risk rating with new financial metrics to create new sustainability and financial risk rating
- Four-point scale
  - 4 = no evident concerns/no regulatory activity
  - 3 = emerging or minor concern potentially requiring scrutiny/potential improvement support
  - 2 = material risk/likely investigation and potential improvement support
  - 1 = significant risk/investigation and potential improvement support

Trust response

- Change comes into effect in Quarter 2 2015/16
- Based on available information, Trust would achieve a sustainability and financial performance risk rating of 3 out of 4.

Changes related to value for money (1)

- *Change 1 – an additional measure within FTs governance rating*
  - Monitor MAY consider investigating if an FT demonstrates inefficient or uneconomical spend (actual or forecast) against published benchmarks.
  - Could include examples of inefficient operational performance, such as poor control over input costs such as agency and management consultancy spend.
  - More details to be published in due course.

Changes related to value for money (2)

- *Change 2 – changes to the Accounting Officer memorandum*
  - In paragraph 7, Accounting Officer must ensure the FT delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation and financial considerations are fully taken into account in decisions by the NHS FT
  - In paragraph 8, reference to Accounting Officer's duty to deliver prudent and economical administration in line with the principles set out in 'Managing public money'.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Agenda item 9

Title:	**Corporate Governance Statement 2015/16 and self-certification**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications as part of the governance statements required to inform the submission of the annual plan to Monitor.
Mission/values:	The Trust's annual plan describes how the Trust will meet its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received and approved the annual plan for 2015/16 on 31 March 2015.
Executive summary:	<u>Background</u> 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. 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. Academic Health Science Centre and governance arrangements for these (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 on behalf of Trust Board by the Chair and Chief Executive in order to make the necessary self-certification by the required date of 29 May 2015. Items 3 and 5 are required by 30 June 2015 and are the subject of this paper. Item 4 is not applicable to this Trust at the current time. <u>Corporate Governance Statement</u> The attached paper sets out the statements Trust Board is required to make and the assurance to support self-certification against the statements. Development of the Corporate Governance Statement included a formal, detailed review of the Trust's compliance with its Licence and Monitor's Code of Governance (see below). 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. <u>Training of governors</u> 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. - Most formal Members' Council meetings include a discussion item, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. Examples include child and adolescent mental health services, the Trust's strategic approach and sustainability, and transformation of Trust services. In 2014, the Members' Council 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. - Attendance at Trust Board meetings. - Attendance at training and development sessions organised by the Trust. - 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. <u>Trust compliance with its Licence</u> The licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all Foundation Trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that Foundation Trusts were to be treated as having met all the licence criteria.

	In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached appendix provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. From quarter 1 of 2014/15, the exception report to Monitor specifically refers to the Trust's compliance with the conditions of its Licence and Trust Board is alerted to any exceptions or emerging risks through the quarterly reporting process. <u>Monitor Code of Governance</u> Monitor's Code of Governance is intended to assist Boards of NHS Foundation Trusts to improve governance practices by bringing together the best practice of public and private sector corporate governance. The Trust has routinely assessed itself against the requirements of the Code and has reported the outcome of this assessment to Trust Board. Although the Code of Governance is not mandatory, Monitor has adopted an approach of 'comply or explain' and Trusts are required to comment on compliance with the Code in their annual reports, including identifying any areas where they do not comply. A self-assessment has been undertaken and the Trust is compliant with the provisions of the Code with the following areas for development in 2015. 1. The Trust's Scheme of Delegation will be reviewed for consideration by the Audit Committee and Trust Board in October 2015. 2. The Scheme of Delegation will include a formal statement of the responsibilities of the Members' Council. 3. The document will also include a clear statement on the division of responsibilities between the Chair and the Chief Executive. 4. Although there is an agreed approach to induction, training and development of governors, further work will be done with the Chair and the Members' Council to ensure this is formalised and more structured in its approach, both individually and collectively, to reflect the enhanced role of governors in the Health and Social Care Act 2012. 5. The Chair will be asked to consider whether there is a need for a formal policy in relation to engagement between governors and directors. 6. The Code of Governance suggests that governors should canvass the opinion of the trust's members and the public, and, for appointed governors, the body they represent, on the NHS foundation trust's forward plan. This remains an area for development and this is an objective for the Members' Council. Further work will be undertaken on how governors can canvass opinion on the Trust's forward plans, bearing in mind the Trust's resources and capacity. A small working group will be established to look at creative ways governors can communicate with members as part of an ongoing work programme. 7. As part of the annual reporting process by the Audit Committee to Trust Board, the Members' Council will be consulted on the Audit Committee's terms of reference.
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 and to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Corporate Governance Statement 2015/16

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.

The Trust continues to implement, develop and improve its 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 statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board took the decision to undertake a well-led governance review during May, June and July 2015. The outcome of this review will be reported to Trust Board in July 2015.

Risks

The outcome of the well-led review is inconsistent with the self-assessment undertaken by Trust Board in May 2015. Mitigated by review and feedback mechanisms led by the Director of Corporate Development with Deloitte, which includes feedback to the Chair and the Chief Executive.

The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.

There are a number of areas to provide assurance to Trust Board that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes and ensures amendments are approved in line with the process set out in the Constitution and as required by Monitor.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where 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 self-assessment was presented to Trust Board in September 2014 and this will be repeated in September 2015.
- The Trust undertakes an annual assessment of compliance against Monitor's Code of Governance and this is reported to Trust Board. An internal audit of the Trust's compliance with the Code in July 2014 found the Trust to be compliant with minor recommendations, including how the Members' Council consults with members on the Trust's forward plans and ensuring the Trust implements the development actions to ensure ongoing compliance with the Code.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers there are no conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a

recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration.

- All elections made to the Members' Council are held in accordance with the election rules in the Trust's Constitution and are overseen by an external organisation (currently Electoral Reform Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence. Trust Board makes a quarterly self-certification as part of the Trust's quarterly return to Monitor and annually receives a full assessment of compliance against the terms of its Licence. For 2015/16, this includes the new licensing condition in relation to integrated care. Should any risks emerge, Trust Board would be informed and action plans to address non-compliance would be put in place to mitigate risk and ensure ongoing compliance. An internal audit review of the Trust's compliance in March 2014 provided a substantial assurance opinion.

Risk

The Trust cannot comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and quarterly reporting to Trust Board as part of the Monitor reporting process.

There are a number of other areas providing 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. The Trust rated green in all four quarters of 2014/15 and is planning to continue to report as green during 2015/16.
- The Head of Internal Audit Opinion for 2014/15 provided significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. An internal audit review of the Trust's corporate governance processes provided a significant assurance opinion in October 2014.
- 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 Foundation Trust Annual Reporting Manual. The Statement for 2014/15 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 and risk register have been assessed as appropriate as part of an internal audit of the Trust's risk management processes. As agreed by Trust Board, a review of both documents has been initiated for presentation in quarter 1 of 2015/16 to improve reporting to Trust Board.
-

2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time-to-time.

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from Monitor, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

Risk

Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.

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.**

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. 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 the public. Trust Board is clear of its accountability and responsibility.

Trust Board and Committee structures in place are effective and meet the requirements of the Trust's Constitution. 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, with the exception of the Audit Committee, 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 deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

From time-to-time, Trust Board has established time-limited Forums, led by a Non-Executive Director, to scrutinise a particular area in more detail. There are three such Forums in place currently in relation to estates, information management and technology, and equality and diversity.

The membership of Committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The Committee structure is reviewed for appropriateness from time-to-time by the Chair.

Each Committee is required to prepare an annual report, which is presented to the Audit Committee. This 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.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge his accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by BDU, and to ensure the work of the EMT is aligned with

that of Trust Board.

The sequencing of EMT meetings continues to provide a 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 with Trust Board processes to ensure Directors receive assurance regarding Trust operations. The weekly Operational Requirement Group, established and chaired by the Chief Executive, continues to meet weekly to ensure and facilitate effective operational delivery of the Trust's annual plan.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Foundation Trust as a whole and the interests of the public. The Members' Council continues to go from strength-to-strength in its ability to challenge and hold Directors to account for the Trust's performance.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors are now in place to provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by the Quality Academy, which provides co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development. Executive Directors have reviewed structures and arrangements within their portfolio areas to ensure these remain fit for purpose and are focussed on providing effective support for operational delivery and to ensure ongoing quality improvement and associated compliance with regulatory requirements.

The organisational development framework allows organisational development work to be tracked in terms of effectiveness. From this framework, a number of workstreams have been developed to ensure the Trust has a workforce fit for the challenges of the future, such as the Talent Pool, Middleground 4 and a values-based recruitment, induction and appraisal programme.

Risk
The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.

4. The Board is satisfied that the Trust effectively implements systems and/or processes:

a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;

b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;

c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;

d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licence holder's ability to continue as a going concern);

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

h) to ensure compliance with all applicable legal requirements.

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 2014/15. There were no issues identified that would need to be reported in the audit opinion. Deloitte also undertook a review of the Trust's financial plan for 2014/15 and 2015/16. Deloitte found that overall, the process had significantly improved and development of the cost improvement programme showed a clear bottom/up approach with clear ownership within and by BDUs. The risk assessment was thorough and was seen to be balanced. The depth and detail of the quality impact assessment and quality of challenge was commended for its rigor providing a well-developed methodology for the Trust to understand the level of risk involved with each proposed cost saving. For the recommendations made in the 2014/15 review, these had been substantially implemented and completed or partially completed. Where only partially completed, this presented no material weaknesses. For the review of the 2015/16 plan, for the majority of schemes, Deloitte concurred with the Trust's assessment of risk to delivery in terms of outcome; however, by value of savings to be realised, Deloitte considered the risk to delivery to be higher. Deloitte also confirmed that the Trust presented more balanced plans for its cost savings for volume and value than in 2014/15 and these were more appropriately focussed and deliverable. Five recommendations were made in relation to:

- BDUs working up delivery plans for all 'red' and 'amber' rated schemes with mitigating proposals to ensure the overall programme is delivered;
- confirmation that there is no overlap between the closure of Castle Lodge and the move to twelve-hour shifts and, if overlap is identified, mitigating action is agreed;
- an assessment of the risk of overlap in Barnsley BDU between the workforce review and the staff vacancy factor and assurance that there is no double counting;
- examination of the quantum savings to be delivered from the transformation of learning disability services to ensure there is clear and consistent understanding of how the project is expected to delivery profiled savings; and
- evaluation and quantification of the extent of investment in re-training and re-skilling required to deliver the learning disability services transformation and how this cost is reflected in the profile of any savings projected.

The Trust's internal audit plan is risk-based to enable the Trust to identify areas of weakness and to learn from best practice. From April 2014 to January 2015, twelve internal audit reports were presented to the Audit Committee. Significant assurance was received for three reports and significant assurance with minor improvement opportunities given in six areas. Three reports were given partial assurance in relation to patients' property, bed management and data quality. Action plans in response to the recommendations made are in place and progress is monitored through the Audit Committee.

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 2013/14 was 103. This equates to the Trust providing services at £5.6 million more than average costs. A number of actions were agreed by EMT to understand the change from the previous year, including continued working with services to improve the data quality of cluster recording and reviewing of service users to ensure the cluster days recorded are accurate, exploration of significant variances from the national RCI using internal and national benchmarking data and monitoring of activity levels and changes in volumes understood.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. The Committee is assured that systems and processes are in place and that service line information is utilised within BDUs. Further work will be done in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives performance reports on a monthly basis with more detailed reports for human resources and customer services presented quarterly. This enables Trust Board to satisfy itself that the Trust is meeting its financial and performance targets. Other reports to Trust Board and its Committees provide 'soft' information that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions from March 2010 and again in May 2011 following the transfer of services under Transforming Community Services. The Trust has a robust process in place to ensure that it meets the requirements of its registration. This is supported by a programme of visits to services which facilitate learning and provide teams with useful experience of an inspection process. The outcome of the visits programme is reported to Trust Board annually with the report for 2014/15 presented in April 2015. The Trust has two compliance actions from a CQC inspection visit to Fieldhead in 2013. The submitted action plan addressing environmental improvements was fully completed by 31 May 2014. 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 and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports and the Trust's annual plan for 2015/16, supported by Audit opinion, the Trust will remain a going concern at all times. As part of its accounts audit for 2014/15, the Trust's external auditor was able to agree with management's view that the Trust could continue as a going concern for the next twelve months. The Trust's annual plan retains the key principles agreed by Trust Board to:

- achieve a recurrent underlying surplus of around 1.0% to 1.5%, which is increased non-recurrently to fund the capital programme (or reduced to provide additional non-recurrent investment);
- ensure continued significant capital investment in 2015/16 funded through use of existing Trust cash balances;
- prioritise capital expenditure, which will enable service redesign, reduce estate costs or generate income through increased service offer;
- achieve a financial risk rating of 3 or above on the Continuity of Service Risk rating;
- demonstrate efficiency of at least 3.5% through the Quality & Efficiency (CIP) savings programme.

The key headlines in the 2015/16 budget are:

- a reduction in income of £3.9 million due to deflation in line with Enhanced Tariff Option;
- delivery of £9.6 million CIP programme in-year which represents 4.4% efficiency, which is 0.9 % above the national requirement of 3.5%;
- pay expenditure uplift consistent with national guidance;
- an additional £11 million investment in services, which is split £6.8 million recurrent and £4.2 million non-recurrent.

The overall position is an underlying recurrent surplus of £3.5 million with an in-year reported deficit of £743,000. The deficit position is due to the increased non-recurrent investment in transformation and technology of £3.1 million, which will enable the Trust to deliver more efficiency in future years and therefore remain clinically, operationally and financially sustainable.

The declaration of sustainability made to Monitor in June 2014 reflected the Trust position that, on its current scope and configuration, it is sustainable financially, operationally and clinically up to the end of year 3. Beyond this timescale, in order to be sustainable, services would need to be part of a bigger entity with critical mass as a specialist mental health and community provider. This has been reviewed and tested by Trust Board and is considered to remain the case for the Trust.

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.

Risk
The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective and independent review of Trust processes.

5. The Board is satisfied that:

a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;
b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care;
d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;
e) 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) 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.

Trust Board continues to use Monitor's Quality Governance Framework as a basis for providing assurance that the Trust has systems and processes in place to deliver quality services. Regular reviews against the Framework have taken place 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.

The Trust produced its Quality Report in 2014/15. 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 2014/15 was externally audited and Deloitte was able to provide the required limited assurance opinion on the content and consistency of the 2014/15 Quality Report and that the content was in line with the Annual Reporting Manual (2014/15) issued by Monitor and consistent with documents reviewed.

In terms of the performance indicator testing of two mandatory targets (care programme approach seven-day follow up and delayed transfers of care) and one local target (pressure ulcers and Waterlow assessments), the overall conclusion was satisfactory subject to implementation of a number of recommendations, which have been accepted by management.

The robust process introduced by the Director of Nursing to assess risk to and impact on quality and safety of cost improvements and efficiency savings proposed by BDUs continued for 2015/16. 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 do not have an adverse effect on Trust services. In 2015/16, assessment of the impact of substitutions or mitigating action will be included in the process as well as cost pressures.

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.

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 is supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

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.

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, the Trust's approach to information management and technology, and equality and diversity. Board-level forums to provide more detailed assurance have been established in the last three 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 process and financial performance 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 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.

The Trust continues to adopt a balanced and measured approach to the publication of the Francis Report and the Government's response. Wherever possible, action has been incorporated into existing processes and procedures. The Trust has published information in relation to the Friends and Family test for staff since 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. In the coming year, the Trust is holding a series of engagement events to update on its plans for transformation and how feedback has been used to inform and influence the Trust's vision for its services.

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.

Risk
The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users/carers and staff, clear process in place for whistleblowing, processes in place for recruitment and selection of Trust Board members.

6. Trust Board effectively implements systems to ensure that it 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 the Trust's NHS provider licence.

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 and to ensure a balance is maintained with skills complementing those of Executive Directors. 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 a 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.

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 a detailed induction programme tailored to individual requirements and Board responsibilities. 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 Governors. Trust Board undertakes ongoing Board development, using external expertise where required, and this will be formalised in the coming year.

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 2015.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the business plan. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Remuneration and Terms of Service Committee. Over the past year, two areas have been strengthened in relation to health intelligence and innovation, and marketing, engagement and commercial development.

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 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. This is demonstrated by the appointment of deputy directors and the establishment of 'trio' arrangements within BDUs. 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 aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level. The Talent Pool is now well-established to identify, nurture and develop talent within the organisation.

Risk
The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 30 June 2015
Monitor provider licence

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

The provider licence is split into six sections, which apply to different types of providers.

1. General conditions – general requirements applying to all licensed providers.
2. Obligations about pricing – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around choice and competition – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable integrated care – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support continuity of service – allows Monitor to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services only.
6. Governance licence conditions for Foundation Trusts – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
General licence conditions (G)		
1. Provision of information	Obligation to provide Monitor with any information it requires for its licensing functions.	The Trust is currently obliged to provide Monitor with any information it requires and, within reasonable parameters, to publish any information Monitor requires it to. Formal articulation of this Condition, therefore, does not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome.
2. Publication of information	Obligation to publish such information as Monitor may require.	
3. Payment of fees to Monitor	Gives Monitor the ability to charge fees and for licence holders to pay them.	Monitor currently has no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for additional fees and this would, therefore, become a cost pressure.

Condition	Provision	Comments
4. Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make an annual declaration against the requirements on an annual basis and has robust arrangements in place for new appointments to the Board (whether non-executive or executive).
5. Monitor guidance	Requires licensees to have regard to Monitor guidance.	The Trust is currently obliged to have regard to Monitor guidance.
6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Corporate Development. Trust Board makes a self-certification quarterly that the Trust remains compliant with its Licence.
7. Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify Monitor is their registration is cancelled.	The Trust is registered with the Care Quality Commission.
8. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	Work is ongoing to formally articulate and publish patient eligibility and selection criteria employed by the Trust. The Trust will include a statement on its website linked to further work to develop service directories for each BDU.
9. Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all mandatory services and "any other service which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS)." See CoS1.
Pricing conditions (P)		
1. Recording of information	Obligation of licensees to record information, particularly about costs.	Monitor requirements in relation to pricing information are still being developed, particularly for care that currently falls outside of the national tariff. However, the Trust will need robust clinical recording systems, capable of producing accurate patient-level costings.
2. Provision of information	Obligation to submit the above to Monitor.	
3. Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	The Trust is working with its commissioners on the implications of the requirements to develop a local

Condition	Provision	Comments
		tariff within the terms of national guidance. The Trust has a memorandum of understanding in place with commissioners relating to the introduction of tariffs for mental health aimed at ensuring the Trust, as a provider, is not de-stabilised when tariff is introduced. The Trust has been using mental health currencies since 2012 and will continue to do so. Work done to date has improved baseline information and enabled a better understanding of the impact of the tariff. This is an area of risk for the Trust in terms of assessing the implications for the Trust's income, and data quality and recording.
5. Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to Monitor for a modification.	See P4 above.
Choice and competition (C)		
1. Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	In 2014/15, a legal right to choice in mental health services was introduced as part of the parity of esteem agenda, covering both choice of mental health provider and choice of mental healthcare team. NHS England produced guidance in December 2014 to support consistent application of the right to choice across the sector. The requirement to offer choice is part of the contractual obligations placed on providers through the NHS Standard Contract and commissioners will monitor progress in implementation through contract management processes in 2015/16. This will be a key area for the Trust to address during the year; however, based on previous experience of the roll-out of choice for physical health services nationally, it is expected that the new legal right will be taken up gradually and not result in significant shifts of activity in the short-term.

Condition	Provision	Comments
2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures. There is a risk to the Trust that challenges on competition could restrict or block service re-design or improvements.
Integrated care condition (IC)		
1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in three Vanguard pilots aimed at developing new ways of working and new models of delivery.
Continuity of service (CoS)		
1. Continuing provision of commissioner requested services	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	All mandatory services were automatically considered as CRS from 1 April 2013. CCGs have a three-year period (i.e. to the end of the 2015/16 financial year) to review this designation. The process for foundation trusts to appeal inappropriate designations will be restricted during this period, which means that providers will only be able to appeal a designation where the contract for that service is coming to an end and they wish to cease provision. For providers that have more than one commissioner, agreement on commissioning across the piece becomes a much bigger issue. There will be a need to ensure commissioners are fully engaged in the service transformation agenda as this has the potential to be deemed a breach of continuing provision.

Condition	Provision	Comments
		Any commissioner requested services no longer provided by the Trust are reported to Monitor as appropriate.
2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in CRS and to seek Monitor's consent before disposing of these assets IF Monitor has concerns about the licensee continuing as a going concern.	As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek Monitor's consent for disposal of assets if Monitor was concerned about its ability to continue as a going concern.
3. Standards of corporate governance and financial management	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place. It reported a green risk rating for both the continuity of services and governance Licence conditions throughout 2014/15 and intends to do the same in 2015/16.
4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	Further guidance on this is awaited from Monitor. It could have the potential to bring significant further financial burden on providers.
6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with Monitor.	The Trust is aware it would need to co-operate with Monitor in such circumstances.
7. Availability of resources	Requires licenses to act in a way that secures resources to operate CRS.	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services.
Foundation Trust conditions		
1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to Monitor.	See G1. The Trust is currently obliged to provide Monitor with any information it requires, including

Condition	Provision	Comments
		information to update its entry on the register of NHS foundation trusts.
2. Payment to Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by Monitor.	Monitor has undertaken not to levy any registration fees on foundation trusts without further consultation.
3. Provision of information to advisory panel	Monitor has established an advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The Advisory Panel was established in April 2013 and the Trust provided a briefing on the Panel for the Members' Council. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Members' Council.
4. NHS Foundation Trust governance arrangements	Gives Monitor continued oversight of the governance of foundation trusts.	The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. The Trust is currently undertaking an independent review of its governance arrangements against Monitor's well-led governance framework, which will conclude with a report to Trust Board on 21 July 2015.

Trust Board 30 June 2015
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.
Values/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 four times since the report to Trust Board in March 2015 in respect of the following. - Licence to occupy rooms within Castleford, Normanton and District Hospital between the Trust and Virgin Care Leeds LLP (dermatology service). - Licence to occupy room at Al-Hikmah Centre, Batley, between the Indian Muslim Welfare Society and the Trust (Kirklees IAPT). - Deed of novation of contract for the provision of 0-5 services between the Trust, NHS England and Barnsley Council. - Lease relating to Queen's Road Clinic, Barnsley, between the Trust and Spectrum CIC.
Recommendation:	**Trust Board is asked to note use of the Trust's seal since the last report in March 2015.**
Private session:	Not applicable