



With all of us in mind

Members' Council
Friday 6 May 2016
From 9:00 (formal meeting starts at 10:00)
Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax, HX1 5ER

Agenda

Item	Time	Subject Matter	Presented by		Action
1.	9:00	Chair's appraisal (Deputy Chair and governors only)	Julie Fox, Deputy Chair	Paper	Interactive session
2.	10:00	Welcome, introductions and apologies	Ian Black, Chair	Verbal item	To receive
3.		Declaration of Interests – annual exercise	Ian Black, Chair	Paper	To agree
4.		4.1 Minutes of the previous meeting held on 12 February 2016	Ian Black, Chair	Paper	To agree
		4.2 Notes from the joint meeting with Trust Board held on 12 February 2016	Ian Black, Chair	Paper	To receive
5.	10:10	Chair's report and feedback from Trust Board Chief Executive's comments	Ian Black, Chair Alex Farrell, Interim Chief Executive	Verbal item	To receive
6.	10:40	Annual plan and budget 2016/17	James Drury, Interim Director of Strategic Planning/Jon Cooke, Interim Director of Finance	Paper/ presentation	To receive
7.	11:00	Transformation update	James Drury, Interim Director of Strategic Planning	Paper/ presentation	To receive

Item	Time	Subject Matter	Presented by		Action
8.	11:20	Implementation of the upgrade to the Trust's clinical information system (RiO) – update	Jon Cooke, Interim Director of Finance	Presentation	To receive
9.	11:40	Performance report Quarter 4 2015/16. The full performance report for month 12 2015/16 is enclosed with these papers and can also be found on the Trust's website at http://www.southwestyorkshire.nhs.uk/about-us/performance/reports/ . There will be a presentation of the key issues at the meeting.	Jon Cooke, Interim Director of Finance	Paper/ presentation	To receive
10.	12 noon	Care Quality Commission – update on our inspection	Mike Doyle, Deputy Director of Nursing	Presentation	To receive
11.	12:10	<u>Members' Council business items</u>			
		11.1 Members' Council elections	Dawn Stephenson, Director of Corporate Development	Paper	To receive
		11.2 Appointment of Lead Governor	Ian Black, Chair	Verbal item	To agree
		11.3 Review of Audit Committee terms of reference	Dawn Stephenson, Director of Corporate Development	Paper	To agree
		11.4 Chair's appraisal – next steps	Julie Fox, Deputy Chair	Verbal item	To agree
12.	12:30	<u>Closing remarks and date of next meeting</u> Friday 22 July 2016 Morning meeting Legends suite, Oakwell Stadium, Barnsley FC, Grove Street, Barnsley, S71 1ET	Ian Black, Chair	Verbal item	



With all of us in mind

**Members' Council
6 May 2016**

Agenda item:	1
Report Title:	Chair's appraisal
Report By:	Julie Fox
Job Title:	Deputy Chair
Action:	To receive

EXECUTIVE SUMMARY

Recommendation

The Members' Council is asked to RECEIVE the following report on the Chair's appraisal.

Background

Good practice and the Monitor Code of Governance suggest that, led by the Senior Independent Director, the Non-Executive Directors should meet without the Chair at least annually to evaluate the Chair's performance, as part of a process, which should be agreed with the Member's Council, for appraising the chair. The process for the Chair's appraisal has followed that of previous years to enable all members of Trust Board and all governors to contribute.

Process

There are three strands to the process for 2016.

1. The Chair has undertaken a self-assessment in the form of an online questionnaire.
2. All Board Directors have been asked to complete an online questionnaire.
3. Facilitated by the Deputy Chair, governors will be asked to assess the Chair's performance in an interactive session on 6 May 2016. *It should be noted that, although done as a group, each governor's response is entirely confidential and responses cannot be attributed to an individual.*

As part of the process, the Deputy Chair will establish with the Lead Governor if there are any additional views or comments he would wish to make or governors would wish to raise, and from the Chief Executive to establish any additional views or comments from Executive Directors. The Deputy Chair will also canvass any additional views and comments from Non-Executive Directors.

If considered appropriate, the Deputy Chair will take into account the views of external stakeholders, such as the Chairs of clinical commissioning groups and acute trusts in the Trust's area to seek feedback on the Chair's performance.

Following the collation of responses, the Deputy Chair and Chair will discuss the outcome and any areas of professional/personal development on a one-to-one basis.

A final report will come to the Members' Council in July 2016 summarising the outcome and any areas for development agreed with the Chair.

**Members' Council
6 May 2016**

Agenda item:	3
Report Title:	Members' Council Declaration of Interests
Report By:	Dawn Stephenson on behalf of the Chair
Job Title:	Director of Corporate Development
Action:	To agree

EXECUTIVE SUMMARY

Purpose and format

The purpose of this item is to provide information regarding the declarations made by governors on their interests as set out in the Constitution and Monitor Code of Governance.

Recommendation

The Members' Council is asked to NOTE the individual declarations from newly appointed or elected governors and to CONFIRM the changes to the Register of Interests.

Background

The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require a register of interests to be developed and maintained in relation to the Members' Council. During the year, if any such Declaration should change, governors are required to notify the Trust so that the Register can be amended and such amendments reported to the Members' Council.

Both the Members' Council and Trust Board receive assurance that there is no conflict of interest in the administration of the Trust's business through the annual declaration exercise and the requirement for governors to consider and declare any interests at each meeting.

There are no legal implications arising from the paper; however, the requirement for governors to declare their interests on an annual basis is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution.

Process

The Integrated Governance Manager is responsible for administering the process on behalf of the Chair of the Trust and the Company Secretary. The declared interests of governors are reported in the annual report and the register of interests is published on the Trust's website.

Members' Council Declaration of Interests

Governor	Description of interest
ADAM, Shaun	No interests declared
ADAMOU, Marios Staff elected, medicine and pharmacy	<ul style="list-style-type: none"> ➤ Director, Marios Adamou Ltd. ➤ Board member, UKAAN ➤ Panel for advising governors, Monitor ➤ Secondary Care Doctor member, NHS East Riding of Yorkshire Clinical Commissioning Group
BAINES, Stephen <i>Appointed, Calderdale Council</i>	<ul style="list-style-type: none"> ➤ <i>Marketing Halifax</i> ➤ <i>Councillor, Calderdale Council</i>
BROWNBRIDGE, Garry Staff elected, psychological therapies	No interests declared
CLAYDEN, Bob Publicly elected, Wakefield	New governor 1 May 2016
COLLINS, Michelle <i>Appointed, Wakefield Council</i>	
CRAVEN, Jackie Publicly elected, Wakefield	<ul style="list-style-type: none"> ➤ <i>Board member, Complex Minds</i> ➤ <i>Board member, Young Lives</i> ➤ <i>Member, Alzheimer's Society</i> ➤ <i>Volunteer, HealthWatch, Wakefield</i> ➤ <i>Parish Councillor, Crigglestone Parish Council</i> ➤ <i>Trustee, Crigglestone Village Institute</i> ➤ <i>Trustee, Worrills Almshouses</i> ➤ <i>Trustee, Hall Green Community Centre</i> ➤ <i>Trustee, 45 Durkar Scouts</i>
CROSSLEY, Andrew Publicly elected, Barnsley	<ul style="list-style-type: none"> ➤ <i>Director, Pathway Sales Limited</i> ➤ <i>Part owner (and shareholder non-controlling), Liaison Financial Services</i> ➤ <i>Consultancy services via Pathway Sales Limited for Liaison Financial Services</i> ➤ <i>Deputy Director, Samaritans, Barnsley</i> ➤ <i>Volunteer mentor, Remedi</i> ➤ <i>Volunteer gateway assessor, Citizens' Advice Bureau</i>
DEAKIN, Adrian Staff elected, nursing	No interests declared
DURES, Emma <i>Appointed, Barnsley Council</i>	
FENTON, Michael Publicly elected, Kirklees	No interests declared
GIRVAN, Claire Staff elected, allied health professionals	No interests declared
HASNIE, Nasim Publicly elected, Kirklees	No interests declared
HAMPSON, Sefanie Appointed, staff side organisations	No interests declared
HAWORTH, John Staff elected, non-clinical support staff	No interests declared
HILL, Andrew Publicly elected, Barnsley	<ul style="list-style-type: none"> ➤ Director, Barnsley Older Peoples' Community Forum
HOLLINS, Chris Publicly elected, Wakefield	
MASON, Ruth <i>Appointed, Calderdale and Huddersfield NHS Foundation Trust</i>	<ul style="list-style-type: none"> ➤ <i>Member, Board of Directors, 'Mind the Gap' theatre company, Bradford, which employs actors with a learning disability</i>
MORTIMER, Bob Publicly elected, Kirklees	<ul style="list-style-type: none"> ➤ Director, Kirklees Community Association ➤ Director, Kirklees Housing Association

Governor	Description of interest
	<ul style="list-style-type: none"> ➤ Director, York House Leisure ➤ President and Director, Golcar British Legion ➤ County President, The Royal British Legion ➤ County Vice Chairman, Service Personnel and Veterans' Agency, Yorkshire and the Humber ➤ Welfare caseworker, Royal British Legion ➤ Welfare caseworker, Veterans' Advice and Pensions and member of Committee ➤ Member, Voluntary Action, Kirklees ➤ Chairman, Kirklees Sports Council ➤ Chairman, Huddersfield and District Amateur Rugby League ➤ Armed forces covenant board
<i>PRESTON, Jules</i> <i>Appointed, Mid-Yorkshire Hospitals NHS Trust</i>	<i>No interests declared</i>
<i>REDMOND, Daniel</i> <i>Publicly elected, Calderdale</i>	➤ <i>Director and Trustee, Calderdale Wellbeing Healthy Minds project</i>
<i>SMITH, Michael</i> <i>Publicly elected, Calderdale</i>	➤ Director, Hour Car (not-for-profit community car share scheme)
<i>WALKER, Hazel</i> <i>Publicly elected, Wakefield</i>	➤ Founder/manager, Bethany House Healing Centre
<i>WALKER, Peter</i> <i>Publicly elected, Wakefield</i>	<i>No interests declared</i>
<i>WILKINSON, Tony</i> <i>Publicly elected, Calderdale</i>	<ul style="list-style-type: none"> ➤ <i>Chair, Calderdale HealthWatch Programme Board (contract for Calderdale HealthWatch held by Voluntary Action Calderdale)</i> ➤ <i>Member, Calderdale Council Health and Wellbeing Board</i>
<i>WOODHEAD, David</i> <i>Publicly elected, Kirklees</i>	<i>No interests declared</i>

Where no return has been received by the Trust, the current entry on the Register has been included in italics.



Minutes of the Members' Council meeting held on 12 February 2016

Present:	Marios Adamou	Staff – Medicine and pharmacy
	Stephen Baines	Appointed – Calderdale Council
	Ian Black	Chair of the Trust
	Garry Brownbridge	Staff – Psychological Therapies
	Jackie Craven	Public – Wakefield
	Andrew Crossley	Public – Barnsley
	Adrian Deakin	Staff – Nursing
	Claire Girvan	Staff – Allied Health Professionals
	Nasim Hasnie	Public – Kirklees
	John Haworth	Staff – Non-clinical support
	Andrew Hill	Public – Barnsley
	Ruth Mason	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Bob Mortimer	Public – Kirklees
	Daniel Redmond	Public – Calderdale
	Michael Smith	Public – Calderdale (Lead Governor)
	Peter Walker	Public – Wakefield
	Tony Wilkinson	Public – Calderdale
	David Woodhead	Public – Kirklees
In attendance:	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Laurence Campbell	Non-Executive Director
	Jon Cooke	Interim Director of Finance
	Rachel Court	Non-Executive Director
	Alan Davis	Director of Human Resources and Workforce Development
	Charlotte Dyson	Non-Executive Director
	Alex Farrell	Deputy Chief Executive
	Julie Fox	Deputy Chair
	Kate Henry	Director of Marketing, Engagement and Commercial Devel.
	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Sean Rayner	District Director, Barnsley and Wakefield
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Director, Calderdale, Kirklees and Specialist Services
Apologies:	Michelle Collins	Appointed – Wakefield Council
	Emma Dures	Appointed – Barnsley Council
	Michael Fenton	Public – Kirklees
	Manvir Flora	Appointed – staff side organisations
	Chris Hollins	Public – Wakefield
	Susan Kirby	Public – Kirklees
	Margaret Morgan	Appointed – Barnsley Council
	Jules Preston	Appointed – Mid Yorkshire Hospitals NHS Trust
	Hazel Walker	Public – Wakefield

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

Ian Black, Chair of the Trust, welcomed everyone to the meeting.

MC/16/02 Declaration of interests (agenda item 2)

There were no further declarations over and above those already made by governors.

MC/16/03 Minutes of the previous meeting held on 6 November 2015 and action points from the development session held on 13 October 2015 (agenda item 3)

The Members' Council APPROVED the minutes from the meeting held on 6 November 2015. There were no matters arising.

With regard to the development session held on 13 October 2015, Ian Black commented that he was disappointed that more governors had not been able to attend. He would like to invite Deloitte to facilitate another session as it is important that the Members' Council receives assurance from other sources aside from the Trust, particularly internal and external audit, and he saw this as part of development activity for governors. He undertook to discuss this further at the next Co-ordination Group meeting.

MC/16/04 Chair's report and feedback from Trust Board/Chief Executive's comments (agenda item 4)

Budgets and annual planning

Ian Black began his remarks by commenting that governors will be aware of the financial challenges facing the NHS currently; however, a new development for annual planning in 2016/17 is the introduction of a 'control total' by NHS Improvement (the organisation that combines Monitor and the NHS Trust Development Agency). A 'control total' of £1.2 million has been set for this Trust. As a foundation trust, the Trust sets and approves its strategic and financial plans and its level of surplus. The Trust is happy to accept guidance and input into its planning process and understands the national position; however, Trust Board, and, in turn, the Members' Council, has to be confident that the Trust can meet its plans and this will include consideration of the implications of the 'control total' from NHS Improvement.

Michael Smith asked if the 'control total' is mandatory and what the implications would be for funding for the Trust. The Chief Executive, Steven Michael, responded that being a foundation trust means a number of freedoms and flexibilities are open to the Trust in relation to its financial plan and Trust Board can determine an appropriate financial position, which the Trust expects to retain to invest in its services. It is difficult for an external body to determine a trust's position without knowledge of its detailed position, commitments and local challenges. Trust Board's view, therefore, is to appreciate the advice and guidance, recognising the challenge for the NHS nationally and that the Trust is part of a broader system. The Trust will complete its annual plan and budget by the end of March 2016 taking into account the Trust's income and investment in services, and will work towards meeting the guidance provided by NHS Improvement.

IB confirmed that the annual planning and budgeting process has begun. Governors will remember that the Trust made a sustainability declaration last year and real challenges remain going forward. A full report will come to the next meeting.

Care Quality Commission (CQC) visit

Covered in more detail under agenda item 8.

IB commented that it is difficult to anticipate the outcome although the Trust's aspiration would be to achieve at least a 'good' rating.

Governor reviews

Governor reviews with the Chair are well underway. These are now a far more two-way discussion and governors are far more proactive with identifying the tools they need, demonstrating an aspiration to be a better governing body with a desire to really make a difference, and identifying where there are gaps.

Steven Michael began by comments with the Prime Minister's announcement that mental health is a priority for the Government. This is very welcome and is a recognition of the challenges faced by the sector; however, there are no new funds available, therefore, commissioners have to see mental health as a priority. Lord Crisp's report into acute adult psychiatric care in England has been published and concluded that people are travelling too far to access treatment. Out-of-area treatment will, therefore, be eliminated by 2017 and four-hour waiting targets will be introduced. Again, this is very welcome as long as it does not lead to a target-driven culture. This report reinforces the development of the West Yorkshire Urgent and Emergency Care Vanguard to improve services through integrated working across the county.

Adrian Deakin asked if there was additional funding for child and adolescent mental health services (CAMHS). Steven Michael responded that there is further investment and the Trust has been invited to express an interest in developing enhanced Tier 3/4 CAMHS and is working with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust to take this forward.

Steven Michael also commented that Barry Sheerman, MP for Huddersfield, has invited him to join a Westminster Commission on Autism reporting in May 2016. The focus of the review is fair access to healthcare and treatment.

He ended by congratulating Paula Phillips, Service Manager/Nurse Consultant in Forensic CAMHS, who was honoured in the New Year's Honours with a MBE. The Trust's previous Medical Director, Nisreen Booya, was also honoured with a MBE for services to healthcare, particularly mental health.

MC/16/05 Potential implications for the Trust arising from the Southern Health NHS Foundation Trust concerns (agenda item 5)

Tim Breedon took the Members' Council through the background to the paper and the assurance provided to Trust Board regarding the Trust's approach to serious incident management. Julie Fox commented that the Clinical Governance and Clinical Safety Committee receives a quarterly report on serious incidents, trends, themes and learning lessons as well as an annual report, which is also presented to Trust Board and the Members' Council. As Chair of the Committee, she also receives notification of all serious incidents, which is very sobering.

John Haworth commented that the report only covers 5 to 10% of unexpected deaths. He asked about the others and whether the Trust was looking at ways to review these. Tim Breedon responded that people in contact with Trust services are part of the Trust's systems and processes; however, there are a number of people not known to Trust services and the Trust is very keen to link with the wider system on suicide prevention. Clinical commissioning groups are keen to take this forward but there are issues for Coroners in releasing information. The Urgent and Emergency Care Vanguard will help put pressure in the system for further work.

Bob Mortimer asked whether the Trust has contact with forces personnel who are referred to services in Birmingham. Tim Breedon responded that there would be a link if the individual had contact with Trust services but, otherwise, the Trust would not be aware.

Tony Wilkinson asked whether the Freedom of Information request from the BBC could include any additional information not readily available. Tim Breedon responded that the Trust's response includes information already in the public domain and immediately available. Tony Wilkinson also asked if it was not mandatory for staff to report unexpected

deaths. Tim Breedon responded that the Trust encourages and supports an open and transparent reporting culture and he will look to change the wording in the report.

Adrian Deakin asked about interoperability of systems. Tim Breedon responded that all Trust staff are aware of the need to record on Datix although the Trust is aware that there are some instances where information has to be duplicated due to different systems in use within different organisations.

Claire Girvan asked if sufficient resource was in place for supported reading. Tim Breedon responded that the Trust works hard to ensure resources are in place although there are occasions when there is pressure on the timing of this.

Steven Michael commented on the useful summary of the Mazars Southern Health report from Mills and Reeve, which particularly highlighted cultural issues within Southern Health at the time. He also commented that no-one should lose sight of the young man whose death led to the review and the report in the first place.

Michael Smith asked how the Trust can be sure there is no Southern Health on the horizon at this Trust. Julie Fox responded that the Trust has good systems in place and this is evidenced by reports to the Clinical Governance and Clinical Safety Committee, which highlights the robustness of these systems. Feedback from families is also very positive. She accepted that no system is perfect; however, she is assured by the Trust's practice. Ian Black added that the Trust should indeed learn lessons but this should be from the best in the sector not necessarily from the worst.

Steven Michael commented on the announcement earlier in the day from the Secretary of State for Health regarding the imposition of new contracts on junior doctors. This is unprecedented in the NHS and the escalation of industrial action will have an impact on Trust services.

MC/16/06 Mandatory and local indicators for the Trust's quality accounts (agenda item 6)

The Members' Council noted that the Quality Group selected gate kept admissions and delayed transfer of care as mandatory indicators for testing, and care planning, in particular whether a care plan has been completed, implemented and reviewed, as the local indicator.

MC/16/07 Performance report Quarter 3 2015/16 (agenda item 7)

Ian Black introduced Jon Cooke, interim Director of Finance, who joined the Trust on 4 January 2016. Alex Farrell then took the Members' Council through the performance highlights and explained the position in relation to improving access to psychological therapies. The Trust is reporting a performance of 71.6% on the six-week access indicator against a target of 75%. This is due to a reduction in capacity as a result of vacancies and maternity leave. The indication from a review of January 2016 data is that the Trust is on target to achieve this in month 10.

Trust clinical information system

She went on to explain the position with the Trust's mental health clinical information system.

A major upgrade was undertaken at the end of November 2015 following detailed testing. She outlined the issues following implementation and the work undertaken to resolve these. Trust Board and the Board's Information Management and Technology Forum were informed. Issues were subsequently found, which the Trust is currently working to resolve

and she very much appreciated staff resilience in coping with the situation. There will be a review of the options open to the Trust by the Executive Management Team and the Trust is in dialogue with the supplier regarding recourse.

Tony Wilkinson asked if clinical staff were aware of the issues and the implications for patients. Adrian Berry responded that clinicians are very much aware as the issues impact on an individual's ability to access and use the clinical information system. Contingency arrangements are in place to limit the impact on patients but there will be an impact in terms of having to run dual systems as an interim measure. Staff concerns centre on their confidence in the system. Marios Adamou commented that the issues have not interrupted patient care but, if the situation was to continue for a prolonged period, this would be a worry.

Steven Michael added that there is only one supplier in the market; therefore, the Trust is tied to using the current contractor. The Trust has commissioned an independent review of the implementation from its external auditor, Deloitte. Alex Farrell also confirmed that this has been treated as a serious incident.

Tony Wilkinson asked whether the Trust has involved governors and Non-Executive Directors in a timely way. Ian Black responded that Non-Executive Directors were informed through Trust Board, the Information Management and Technology Forum, which he chairs, and through serious incident reporting. He was of the view that Non-Executive Director involvement had been timely and appropriate. In relation to governors, the incident took place very near to the last meeting and was, at the time, operational in nature. His judgement, therefore, was that the situation was being managed effectively and it was not necessary to communicate to the Members' Council at that time. Alex Farrell commented that, although the issues arose from the implementation, it was only in January 2016 that significant issues came to light and were reported to the Information Management and Technology Forum on 5 January 2016 and Trust Board on 29 January 2016. The position was only really clear towards the end of January 2016 so the Members' Council meeting today is very timely.

Steven Michael commented that the Trust will use internal audit and the independent review to assess whether internal controls could or should have identified issues and problems.

Finance update and other performance issues

Jon Cooke took the Members' Council through the financial position. John Haworth asked how the Trust could now plan for a surplus when it is not achieving its cost savings target. Jon Cooke responded that contingencies in the plan are used to offset underperformance. Ian Black commented that Trust Board is confident that the Trust will achieve its end-of-year forecast. Laurence Campbell added that, although non-recurrent substitutions will fill the gap, this may present issues for 2016/17.

Stephen Baines asked about the early intervention in psychosis target. Alex Farrell responded that the target is set historically on an assumption of numbers and this has not changed over time. In 2016/17, a whole suite of new, more relevant indicators will be introduced.

Ian Black clarified that commercial negotiations are currently in place to dispose of a piece of land owned by the Trust and this will be included in the report at quarter 4.

Garry Brownbridge commented that the improving access to psychological therapies service is small and works at primary care level. The Trust also has psychological therapy services across its districts at secondary care level and these also have targets, which are being met.

He suggested it would be fairer to reflect performance across Trust services to give a balanced picture.

Adrian Deakin expressed a concern regarding agency costs at the six-month point. Alex Farrell responded that agency costs are monitored closely. A cap has been introduced nationally through a phased approach and the Trust is compliant with national requirements. A key issue is the ability to recruit speciality doctors and agency staff are used to cover the work. Work has begun to develop a more sustainable workforce model to reduce and limit the need for agency staff.

John Haworth asked about the vacancy rate. Alex Farrell responded that the Trust is currently working through the metrics and it will be reported in quarter 4.

MC/16/08 Care Quality Commission – preparing for our inspection (agenda item 8)

Ian Black commented that the Trust took the decision not to commission an independent assessment of readiness. Trust Board considers this to be a good Trust, which is aware of its weaknesses. He was pleased with the thoroughness and robustness of preparation, particularly the programme of unannounced and announced visits. Also, there are people within the Trust who have taken part in or chaired visits or are expert advisers to the CQC. He confirmed that the Trust's report would be published on its website.

MC/16/09 Trust Board appointments (agenda item 9)

Re-appointment of Non-Executive Director (agenda item 9.1)

Jonathan Jones left the meeting for this item.

Ian Black outlined the rationale and the exceptional circumstances influencing the proposal. **The Members' Council APPROVED the proposal to re-appoint Jonathan Jones for a further year to 31 May 2017.**

Ratification of Chief Executive appointment (agenda item 9.2)

Ian Black explained the process undertaken culminating in interviews on the 10 and 11 February 2016. It was the unanimous view of the panel to appoint Rob Webster, currently Chief Executive of the NHS Confederation and with previous Chief Executive experience in Leeds and Calderdale. He believed it was an excellent appointment for the Trust. He confirmed that Rob Webster has accepted the offer. **The Members' Council RATIFIED the appointment of Rob Webster as Chief Executive of the Trust.**

MC/16/10 Members' Council business items (agenda item 10)

Members' Council elections (agenda item 10.1)

The report from Dawn Stephenson was noted.

Members' Council work programme (agenda item 10.2)

The Members' Council APPROVED the work programme for 2016.

MC/16/11 Date of next meeting (agenda item 11)

The next meeting will be held in the morning of Friday 6 May 2016 at the Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax, HX1 5ER.

On behalf of the Members' Council, Michael Smith thanked Steven Michael and expressed his appreciation for his time as Chief Executive of the Trust. He is leaving the Trust in a

great place and the Members' Council is happy that his successor has such a good legacy to build on. He also thanked Steven for his personal support and wished him well for the future. Steven Michael responded that this had been a long journey for the Trust. The organisation is rooted in its communities, which is reflected in an involved and engaged membership able to challenge, with the type of Members' Council the Trust should have and deserves, and which is treated with dignity and respect by the Board and all in the organisation.

Signed **Date**

DRAFT



With all of us in mind

**Joint Trust Board/Members' Council meeting
12 February 2016
Annual plan 2016/17**

1. Introduction

Ian Black welcomed everyone to the joint Trust Board and Members' Council meeting. The focus of this session is the Trust's forward plan for 2016/17 and the implications of this in future years. This is a key part of the Members' Council role to support the Trust in preparing its forward plans and this is much appreciated.

2. The importance of NHS governors

A video message from Dame Gill Morgan, Chair, NHS Providers, was shown, which outlined how important governors are to the governance arrangements within NHS foundation trusts. Part of her message was to highlight the "top three things" governors should be thinking about and, before this section of the video was played, the Members' Council was asked for its views of what these are.

Dame Gill Morgan	Our Members' Council
<ol style="list-style-type: none"> 1. Money 2. True to quality 3. Across boundaries of the NHS 	<ol style="list-style-type: none"> 1. Effective, efficient, economic local services – value for money. Accessible and understood. Patient satisfaction Happy partners and other stakeholders 2. Individual, personalised services 3. Clinical quality 4. Governance 5. Context (our Trust in the community) 6. The future of health services

3. Our strategic context and environment

Steven Michael, Chief Executive

- The Trust must be cognisant of the importance of the wider 'body politic' in shaping what it does. Political influence shapes the context the Trust works in.
- The NHS has received a very challenging settlement from the Government. When linked to reductions in local authority funding, the NHS faces a very difficult situation.

- Acute providers are at the forefront of the public's perception of the NHS to the detriment of mental health and learning disability services. Acute Trusts dominate the agenda both with the public and with commissioners, and any discussion about healthcare. This is at odds with the Prime Minister's declaration that mental health is a priority.
- This has led to a very challenging set of contracting negotiations with commissioners where the national message is not translating into reality.
- The Trust must continue to ensure it focuses on its mission and values and concentrates on what it is here for. Moving forward, it is important that the Trust does not lose sight of this, which presents a challenge for development of the Trust's own plans.

4. Key assumptions/priorities for annual planning

Alex Farrell took the Members' Council through the planning requirements and the key financial headlines.

5. Facilitated group discussion

The Members' Council and Trust Board divided into four groups (focusing on core mental health services, specialist services, forensic services and general community services) to consider the following.

- *The Members' Council identified a number of themes last year as being important in terms of the Trust's plans. (These are outlined below.)*
- *In a changing external environment, which is much more challenging, are these themes still important?*
- *Or, do we need to do something more radical in what we think of as core provision?*
- *And what could be provided by someone else?*

Themes from 2015 forward plan discussion.

- | | |
|---|--|
| ▪ Partnership, partnership, partnership | How do we facilitate/lead co-operation against organisational interests?
How do we create local provider solutions?
How do we share information? |
| ▪ Ensuring the voice of mental health is heard | Parity of esteem
Link to physical health |
| ▪ Increase in demand at both ends of our services | How do we address this under current funding arrangements, in a time of reduced income and against potential de-commissioning of services? |
| ▪ Transformation/service development | How, when and why and how funded?
Take out areas that don't work |

Invest in prevention and recovery
 How do we use technology to support our services, service users and staff?
 Trust services need to be responsive, outcome-focused and predicated on needs

▪ Workforce

How do we attract young people to work for us?
 How do we make our workforce flexible and diverse?
 How do we ensure our staff are fit and well to care?
 How do we ensure we can remain competitive with the workforce we have?

Group 1 – core mental health services

Facilitated by Charlotte Dyson Karen Taylor	Supported by Jon Cooke	Group members Marios Adamou Andrew Crossley Daniel Redmond Peter Walker
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Feedback – priorities

- Increase support and care in the community.
- But, keep core acute provision, which will still be needed in exceptional circumstances and as a last resort.
- Work in partnership and across agencies to provide services.

Feedback – detail

Constraint – inpatient mental health provision – but we can use partnership working so

- in-patient only for acute need
- in-patient only for the minimum time (for those who can)
- some service users can be supported in the community (and use our partners)
- use data and technology to ensure good communication across the pathway (“only tell your story once”)
- increase the amount of intensive home-based treatment and care in the community.

Increase support and care in the community. Enabled by:

- in conjunction with other partners – social care, third sector, acute sector
- Creative Minds/Recovery Colleges/Altogether Better

Work more closely with other local areas, such as Bradford, Sheffield, Leeds (so less travel) and work within a whole system.

Key message – maintain mental health in communities

All reliant on staff

- Strong engaged workforce

- Career structure in place
- Engage with schools, universities, colleges

Group 2 – specialist mental health services

Facilitated by Julie Fox Tim Breedon	Supported by Alex Farrell Kate Henry	Group members Garry Brownbridge Nasim Hasnie
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Feedback – priorities

- Maintain effective partnerships recognising the importance of system-wide work in a difficult climate
- Be clear about what we do, why and how we can evolve (with evidence).
- Do more work on patient advocacy and ensuring people get what they need. Champion the needs of people not the system.

Feedback – detail

Partnerships are crucial

- to support people in their own homes
- for preventative/early interventions
- clarity around responsibilities and what we do/our evidence-based impact
- understanding, communication and engagement
- information sharing/resource sharing
- increase internal partnerships
- increase ‘tough’ conversations

Ensuring voice of mental health is heard

- increase our role in promoting clarity about what mental health is/what we are here for
- increase service user stories
- link to national promises, such as the Prime Minister’s comments
- advocate for mental health
- promoting anti-stigma conversations
- advocate for quality and service user experience campaigner

Workforce

- Sustainability issue
- Re-skilling for new world

Group 3 – Forensic services

<u>Facilitated by</u> Rachel Court Jonathan Jones Adrian Berry	<u>Supported by</u> Dawn Stephenson	<u>Group members</u> Jackie Craven John Haworth Bob Mortimer David Woodhead
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Feedback – priorities

- The Trust should retain forensic services as part of its offer.
- Our unique selling point is pathway management and the Trust should promote it.
- Build on our partnership approach – look for opportunities and position the Trust as a lead provider.

Feedback – detail

- The Trust is a large and diverse provider across the Yorkshire and Humber footprint with services providing a margin.
- Whole pathway approach is more effective and is better for service users.
- Partnership approach – develop networks with other providers; getting people back to their local communities.
- Opportunities – lead provider and sub-contract elements of the pathway; young offenders/prisons; utilise estate and expertise of staff.

Group 4 – general community services

<u>Facilitated by</u> Laurence Campbell Chris Jones Sean Rayner	<u>Supported by</u> Alan Davis	<u>Group members</u> Adrian Deakin Claire Girvan Andrew Hill
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Feedback – priorities

- Review four-tier model for ‘fit’ with our offer: decide whether a priority, including inter-dependencies.
- Emphasis on self-referral services.
- Link to preventative agenda.

Feedback – detail

- Review new four-tier model to fully allocate services and review areas to build and to exit.
- Develop criteria to make these decisions.
- Define tier 1 as self-referral services
- Map inter-dependency of the four tiers

- Develop branding of the service offer
- Link to the preventative agenda

6. Next steps

Three key themes emerging from the session.

- We need to stay on the pitch – we need to continue to do the day job successfully and effectively.
- We need to be an agent for change – we need to be an advocate for what will make a difference for people who use our services.
- We need to work effectively with our partners – we need to be clear where we will partner and who we want to partner with.

Steven Michael

This was a constructive session, which will support the Trust to pull together a coherent plan and budget in a difficult and challenging time. It is excellent that the Members' Council is able to inform the content and prioritisation of resources in support of Trist Board.



With all of us in mind

**Members' Council
6 May 2016**

Agenda item:	6
Report Title:	Annual plan and budgets 2016/17
Report By:	James Drury/Jon Cooke
Job Title:	Interim Director of Strategic Planning/Director of Finance
Action:	To receive

Background

NHS Improvement (which brings together Monitor and the NHS Trust Development Authority from 1 April 2016), NHS England and other national bodies issued integrated planning guidance for NHS provider and commissioner organisations. There are two forms of plan required for 2016/17:

- a single organisation operational plan for 2016/17 from each NHS provider, which was to be submitted to Monitor on 18 April 2016; and
- an integrated place-based Sustainability and Transformation Plan (STP) required from each 'footprint' by June 2016. Locally this means a plan for West Yorkshire and a plan for South Yorkshire, supported by place-based plans at local authority level.

The operational plan required the Trust to consider the following elements and their impacts on each other, and the impact of the emerging STP on the Trust's plans and vice versa. This related to:

- **Activity**, which should be in line with demand and capacity analysis, Trust workforce plans and commissioning intentions/national guidance;
- **Quality**, which should include quality priorities, risks to quality and a focus on quality improvement, and must triangulate with workforce and finance;
- **Workforce**, which should include major drivers of workforce change and the impact on staff numbers, and should correlate with finance and quality, and with external and partnership agendas, such as New Models of Care;
- **Finance**, which should reflect the combined impact of the above and ensure the Trust is setting a safe, realistic and suitably ambitious financial plan.

The Trust is also required to set an annual budget, which is approved by Trust Board.

The Trust's operational plan must be seen against a national context of continued financial pressure across the NHS and a forecast deficit for the sector in 2015/16. Locally, the Trust has delivered its 2015/16 planned outturn; however, it has delivered a lower than planned cost improvement programme, which impacts on the 2016/17 opening position. There are also significant new commitments in 2016/17, such as, changes to National Insurance contributions, which will impact on the Trust's financial position. NHS Improvement has requested a control total of £1.2 million surplus for the Trust.

Process

At its meeting in March 2015, Trust Board considered the draft one-year plan and the annual budget and provided robust challenge in a number of areas focussing on:

- the cost improvement programme, the timescales for achievement of a challenging programme and areas of risk;

- the supporting Quality Impact Assessments undertaken to assess risk to the quality of services and the assurance this process provides to Trust Board;
- the Trust's transformation programme and how and when it would contribute to the service changes and efficiencies needed for future years;
- the plan to deliver a challenging capital programme in 2016/17.

During 2016/17, Trust Board will continue to robustly scrutinise progress against the cost improvement programme through finance and performance reports.

Trust Board unanimously approved the annual budget for 2016/17 and the allocation of capital funding on 29 March 2016. It also supported the content of the operational plan and delegated authority to the Chair, Deputy Chair, Interim Chief Executive and Interim Director of Finance to approve the final version of the plan for submission by 18 April 2016.

Deloitte was commissioned to provide an independent review of the Trust's plans for implementation of the 2016/17 along similar lines as the exercise undertaken in the previous two years. The outcome of this review will be presented to Trust Board at its meeting on 28 April 2016.

Operational plan 2016/17

The Trust's strategic approach was set out in its five-year strategic plan (appendix 1), which was originally presented to the Members' Council in July 2014. The key principles of this approach continue to underpin the Trust's strategic plan and its objectives. The operational plan submitted to NHS Improvement is attached at appendix 2. It sets out the Trust's approach to activity, quality improvement, workforce and finance, and links to sustainability and transformation planning.

The Trust will work with commissioners to ensure that its services are responsive to the national 'must do's' for each local health and care system to address in 2016/17. There are four relevant to Trust services, which focus on the following.

1. Return the system to aggregate financial balance.
2. Referral to Treatment standards (92% 18 weeks).
3. Implement mental health access standards:
 - over 50% people experiencing first episode psychosis commence treatment with NICE approved care package within two weeks of referral;
 - over 75% referrals to improving access to psychological therapies treated within six weeks, and 95% within 18 weeks;
 - continue to meet dementia diagnosis rate of at least 2/3 of estimated number of people with dementia.
4. Deliver local transforming care plans for people with learning disabilities, including enhanced community provision, reducing inpatient capacity and care and treatment reviews

Key principles – financial plan

The annual plan has retained the key principles agreed by Trust Board as described below.

- A recurrent underlying surplus which is increased non-recurrently to fund the capital programme.
- Continued significant capital investment in 2016/17 funded through use of existing Trust cash balances.
- Prioritising capital expenditure, which will enable service redesign, reduce estate costs or generate income through increased service offer.
- A Financial Risk Rating of 3 or above on the Continued of Service Risk rating.
- Demonstrate efficiency of at least 3.5% through the quality and efficiency savings programme.

The key headlines in the 2016/17 budget are as follows.

- An increase in healthcare income of £1.4 million due to the inflationary increase to the national tariff.
- Delivery of £10.1 million CIP programme in year which represents 4.7% efficiency.
- Pay expenditure uplift consistent with national guidance.

- Additional £4.4 million investment in services, which is split £3 million recurrent and £1.4 million non-recurrent.



The key elements of cost pressures of £6.8 million:

- safer wards and staffing investment £0.8 million
- clinical staffing £0.7 million
- Quality Academy staffing £0.6 million
- estates strategy £0.6 million

The current budget plan reflects current income assumptions; however, an element of risk remains even though the Trust operates on a block contract due to the continuing pressures within the NHS.

NHS Improvement has requested a control total of £1.2 million surplus for the Trust. At its meeting on 29 March 2016, Trust Board agreed that the Trust will endeavour to work to the control total set, subject to the Board being satisfied that it can be delivered without compromising patient safety and can be confident of overall delivery. Therefore, a budget has been set to provide a £500,000 surplus, which takes account of a £750,000 investment for safer staffing. This position will be reviewed when the inspection report is received from the Care Quality Commission. As a result, the overall position is an underlying recurrent surplus of £1.12 million with an in-year reported surplus of £500,000.

The cash position remains healthy and is supporting a proposed £16 million capital programme in 2016/17.

The overall Monitor financial risk rating for the plan is 4 out of 4.

The Trust's risk rating is set out at appendix 3 and the summary annual plan position at appendix 4.

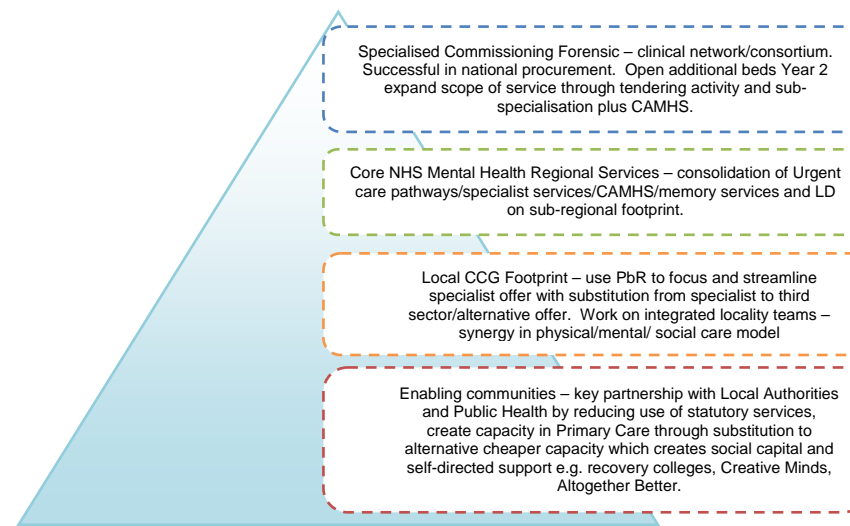
Five-year strategic framework for sustainability

The Trust's chosen plan for sustainability is predicated on:

- driving hard on CIPs through transformation in years 1 to 3; and
- increasing our focus on income generation through service line specific plans.

In addition, the plan recognises that the challenges of sustainability for the services we provide become increasingly challenging at the current scale from Year three onwards; therefore the emphasis is additionally on the following:

- growth through partnership to find a sustainable platform for the delivery of each strata of service provision;
- achieving scale and operating model efficiency in support services to serve an increasingly dispersed internal customer base;
- continuing the journey towards enabling recovery and promoting self-care.



Operational Plan 2016/17

PUBLISHABLE VERSION

18th April 2016

James Drury – Interim Director of Strategic Planning



With all of us in mind

Contents

Section	Pages
Approach to Activity Planning	3 to 4
Approach to Quality Improvement	5 to 13
Approach to Workforce Planning	14 to 16
Approach to Financial Planning	17 to 22
Links to Sustainability and Transformation Planning	23 to 24
Membership and Elections	25 to 26



With all of us in mind

1.1 Approach to Activity Planning

Activity Planning Assumptions for 2016/17

- Population growth increases overall activity marginally (less than 1%) in line with ONS projections
- Acceleration of seven day working in local acute hospitals drives demand for growth in community activity as rate of discharge accelerates. Plan assumes 4.4% growth in contacts.
- Exit from the 0-19 public health contract in Barnsley reduces overall community contacts 12.4%
- Activity in secure mental health occupied bed days increases marginally (less than 1%) with trend towards more low secure bed days and fewer medium secure. Trend towards reducing length of stay in forensic mental health beds continues.
- Acute mental health beds continue to be fully utilised. Trend toward reduction in use of out of area beds continues as a result of work on process efficiency, gatekeeping, and alternatives to admission.
- Investment in CAMHS and focus on productivity reflected in increased contacts, based on out turn (1.2%)
- Impact of Transforming Care on demand for local learning disability assessment and treatment beds increases planned occupied bed days by 7.8% compared to 15/16 plan. Implementation of new models of care in community will support more community placements.
- As a result of service reconfiguration the number of beds reduces in the Trust's forward plans by 24. This includes changes in substance misuse, older peoples mental health and mental health rehab. This is also reflected in occupied bed days.



With all of us in mind

1.2 Approach to Activity Planning

How system resilience planning informs 16/17 activity plans

The draft 16/17 activity plan is based on 2015/16 forecast out turn. This includes any additional activity related to winter resilience, police liaison and hospital based psychiatric liaison services.

Matching Capacity to Demand

We have used various safe staffing indicators to test the sufficiency of our ward based staffing levels and skill mix to meet the needs of service users, including with reference to changes in acuity. We are also making more frequent use of our own staff bank and developing an additional peripatetic workforce that can be deployed flexibly. This will support us reducing the use of agency nursing staff.

In the Barnsley health system an acuity measurement tool is being introduced to match capacity to demand and ensure optimum bed utilisation at every level. We are working with Meridian Productivity to optimise the use of our clinical workforce in older peoples mental health and in community services. We have also added capacity in psychology within some localities to ensure we are better able to address demand and waiting times.

Achieving key operational standards

We currently achieve all KPIs (Monitor RAF) with the exception of the IAPT access standard (first treatment within 6 weeks). Since first reported in Q3 15/16 the performance trajectory has been positive and we are planning to achieve the standard in 2016/17.

New standards apply to Early Intervention in Psychosis (EIP) services from April 2016/17. In February we achieved 88.24% for completed pathways against the two week access standard (target 50%). However there is more to do on EIP to ensure we have sufficient staff and an optimised skill mix in place. This is required to meet growth in demand arising from expansion of the age range for EIP, extension of the model to include people at risk of psychosis and the requirements for new therapies. A project is underway to support delivery of this important operating standard.



With all of us in mind

2.1 Approach to Quality Improvement

Our approach to quality improvement

A drive for continuous improvement is embedded in our mission and values. As a learning organisation, we encourage all of our staff and service users to make suggestions for quality improvement and be involved in implementing the great ideas that are adopted. Our philosophy is

- Quality Improvement occurs as near to people who use our services as possible
- Quality is everybody's business
- The quality of non-clinical services is as important as the quality of clinical services in the delivery of the SWYPFT commitment.
- Support for quality improvement is available to ensure change initiatives are successfully implemented.

We adopt a process for quality improvement based on the 'Seven Steps to Quality': Bring clarity to quality, measure quality, publish quality, partnership for quality, leadership, innovation, and safeguarding quality.

How quality and safety will be maintained and improved throughout the year

We routinely report on quality improvement to Trust Board including as part of an integrated performance report. In addition we learn through a robust clinical audit programme, we participate in Research and Development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives including the national confidential enquiry. We also have an active programme of mock CQC visits to all our operational areas, from which we derive significant learning and quality assurance.

We have developed an innovation framework and we are embedding continuous quality improvement in all our services through an adoption of the Clinical Microsystems approach, which will encourage customer focus and reflective practice in all teams. Our Quality Impact Assessment Process is used throughout the year as initiatives are developed.



With all of us in mind

2.2 Triangulation of Quality, Activity & Finance

Our approach to triangulation

Our approach to triangulation takes place at Trust Board, Executive Team, Locality and Service Line levels. During 2016/17 we will further develop individual team level balanced scorecard dashboards to ensure that quality and performance measures are understood and used meaningfully at all levels.

Trust Board receive a monthly Integrated Performance Report and each Quarter there is a more extensive review of trend analysis. The KPIs used fall into the following categories;

- Business Strategic Performance – Impact and Delivery including external regulator measures
- Customer Focus
- Operational Effectiveness – process effectiveness, Risk Assessment Framework (RAF) quality indicators and data quality
- Fit for the Future – Workforce including sickness, vacancies and mandatory training

Using Learning to Improve Quality of Care

During 2015/16 we have been able to use the approach outlined above to inform action and demonstrate improvement in the following areas: Compliance with mandatory training; CAMHS quality of care; Safer staffing ward 'fill rates'; Recovery Colleges; Friends & Family Test scores; and learning from SI's that have led to improved quality

During 2016/17 we will continue to use this clear 'line of sight' on quality, performance and finance to drive improvement on productivity (Meridian opportunities) and quality (focus on clustering and care planning, improving physical health of MH patients, improving clinical information and data quality)



With all of us in mind

2.3 Approach to Quality Improvement

Description of Trust quality improvement governance systems

Quality Improvement is a priority at Board level and throughout the Trust. The Executive Lead is the Executive Director of Nursing, Clinical Governance and Safety. We also have a Director of Health Intelligence and Innovation ensuring that knowledge derived from a wide range of data is applied in our Quality Improvement work. The **Clinical Governance and Safety Committee (CGSC)** is led by the lead Executive Director and a Non Executive Director counterpart. This committee reports directly to Trust Board. Reporting in to the CGSC are a series of standing sub-groups covering the full range of clinical quality and safety matters. These are each chaired by either the Medical Director, Nursing Director or their deputies.

Central to this is the Trust's **Quality Improvement Group**. The purpose of the group is: to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Improvement strategy. The functions of the group are: Horizon scanning; interpretation and reporting of relevant national/local quality and safety directives; Critical consideration of organisational quality and safety improvements; Information sharing; Risk scanning; Discussion, debate and planning

Our Quality Priorities

We have seven quality priorities that have been agreed through wide engagement with service users, staff and our Members Council. They are:

Listen and Act	Improve care and care planning	Transfers across care pathways	Improve safety for people
Access	Improve recording and evaluation	Staff fit to undertake duties	

Each year the specific actions we will take under each of the seven quality priorities are agreed in line with learning. These are set out in our Quality Improvement Strategy. This is currently being refreshed for 2016/17 and will include a focus on encouraging innovation.



With all of us in mind

2.3 Approach to Quality Improvement

Our Quality Priorities for 16/17

Our quality priorities remain consistent, but we review the specific actions to be taken each year to reflect the needs of our service users and learning from our quality Improvement systems. The focus for 2016/17 will be

Priority	Actions
Patient experience	Development of systems in services where FFT or service user experience feedback mechanisms are not as effective as they need to be
Access	Mental health access waiting times, including the EIP and IAPT access standards
Care and care planning	Physical health care plans; Risk assessments Quality standards – standard operating procedures for care plans and risk assessments
Clinical information and data quality	Implementation of action plan -Top 10 key issues to improve clinical record keeping Monitor IG breaches and development of quality dashboard
Pathways of care	Transitions – urgent care concordat in CAMHS / Learning Disabilities / adult interface. Teams working together for improved service and efficiencies
Staff well being	Develop a Trust-wide system for recording and reporting clinical supervision Whistleblowing systems. Pledge – staff to publish and celebrate their work Extensive use of Staff Survey for early identification of issues and to focus effort
Safety	Mental Health Safety Thermometer (MHST) including CAMHS Suicide prevention strategy implementation Governance peer review schemes - robust systems and process are in place to identify quality hot spots and take prompt, effective action.



With all of us in mind

2.3 Approach to Quality Improvement

Our Patient Safety Strategy including 'sign up to safety' priorities for 16/17

We integrate our 'sign up to safety' pledges into our Patient Safety Strategy. Priorities for 16/17 are currently under review, however we anticipate a continued focus on the following, which we have been working on throughout 2015/16;

Focus	Rationale	Measures
Falls	Falls and related injuries are preventable. human cost of falling including loss of independence. Financial costs.	To reduce frequency of falls by patients in an inpatient setting by 15% by 2018 while still undertaking positive risk
Medication omissions	For some critical medicines delays or omissions can cause serious harm or death	To reduce unintended missed doses by 25% by 2018
Pressure Ulcers	Pressure ulcers are often preventable. Nearly 700,000 patients are affected each year	To reduce the frequency of incidence of new pressure ulcers attributable and avoidable to our care by 50% by 2018
Prone Restraint	Variation in use of restraint nationally. Prone restraint can cause injury, prolong admission and affect therapeutic relationships	To reduce the number of instances of prone restraint and monitor the duration of episodes of prone restraint
Injuries following restraint	In some instances nationally restraint has caused serious physical and psychological trauma	To reduce incidents of restraint resulting in moderate/severe harm



With all of us in mind

2.4 Approach to Quality Improvement

Risks to Quality

Risks	Mitigation and Treatment
Maintaining quality in times of austerity	Financial planning strategies Efficiency & effectiveness programmes of work (e.g. Meridian productivity work) Quality Impact assessment process
Maintaining quality whilst we are transforming our services	Deputy Director, Assistant Directors of Nursing are part of transformation work as are the Practice Governance Coaches in operational leadership teams Engagement with staff, service users, and other key partners Quality Improvement Group focus on horizon scanning. Oversight by Clinical Governance Group
Developing partnerships to work together to deliver services without leaving gaps that compromise safety	Engagement in Vanguard work streams Partnerships with wide range of local partners including CCGs LAs and NHSE Clarity of roles and responsibilities within partnerships – to avoid ‘gaps’ Clear mapping of stakeholder relationships and identification of priority partnerships to develop in order to develop extended care pathways
Recruitment of clinical staff	Established values-based assessment and recruitment centres. Established marketing approach to target graduates and experienced clinicians. Preceptorship offer to newly qualified staff nurses. Induction package for staff joining the organisation. Talent management programme



With all of us in mind

2.4 Approach to Quality Improvement

Risks to Quality - continued

Risks	Mitigation and Treatment
Transitioning public services to local authorities (or their new provider) where we exit specific services	Strategic review of contracts plus legal advice as needed Exit strategies including service user and staff engagement, treatment continuity plan at individual level
Addressing need for clarity of purpose and operating model in mental health rehab units	Clinically led pathway discussions underway with commissioners. Staff and service user engagement accelerated. Work on underpinning recovery philosophy
Managing the physical disruption related to the Fieldhead wards building development work	Designated decant facility in place. Significant service user and staff engagement
Embedding the new prison CAMHS service safely into the work of the Forensic BDU	Due diligence – and subsequent action plan Focus on staff induction, training and engagement Undertake internal 'mock CQC' visit
Movement to enhanced and core services in community mental health	Phased transition with clinical leadership and oversight of quality KPIs throughout by 'practice governance coaches' Clear Standard Operating Procedures
Ensuring clarity of roles and responsibilities in respiratory and diabetes pathways which are moving towards 'year of care' payment models	Clear pathway and Standard operating procedures common to all partners Clinical oversight of model of care



With all of us in mind

2.5 Approach to Quality Improvement

Our focus on 'Well-Led'

In 2015 we commissioned a well-led governance review which was undertaken by Deloitte, which confirmed substantial assurance in the Trust's leadership. The learning from this review is being implemented in 2016 through the delivery of an action plan monitored by the Executive Management Team.

In every service area we undertake mock-CQC inspection visits which use the same KLOEs as CQC. Through this process we review the 'Well-Led' elements and follow up the completion of any actions arising.

We also have an ongoing programme of leadership development for all those with managerial and clinical leadership responsibilities. This includes team-based coaching, a comprehensive 'middle-ground' programme aimed at AfC band 7s and above, and access to a range of internal and external development opportunities e.g. through the NHS Leadership Academy.

Seven Day Services

Our approach to improving access to services across all relevant days and times of the week is being developed through our transformation of mental health Single Point of Access services, crisis and home based treatment services and through the West Yorkshire Urgent Care Vanguard which includes a focus on liaison with police and general hospital services. These will primarily be the vehicles through which we ensure appropriate access to mental health services.

Within our general community services, including intermediate care, seven day service provision is in place and has been further developed in recent years in line with step changes in weekend discharges from local acute hospitals.



With all of us in mind

2.6 Quality Impact Assessment Process

Identification of Cost Improvement Plans (CIPs)

Efficiency opportunities are identified through both Trust-wide transformation initiatives and through annual service line planning exercises. This is supported by internal and external benchmarking and market analysis. Schemes are documented on a simple standard template to aid clarity

Quality Impact Assessment (QIA)

At the time of scheme identification service line teams undertake a self assessment of QIA. This follows key lines of enquiry addressing safety, clinical outcomes, experience and engagement. The Impact assessment process also involves consideration of feasibility and achievability as well as impact on quality.

A series of QIA panels review all CIP proposals using KLOEs in discussion with leads for each service line. This allows self assessed QIAs to be peer reviewed with support from clinical governance and safety experts. Panels are chaired by the Assistant Director for Nursing, Clinical Governance and Safety. RAG ratings for finance, deliverability and quality impact are brought together into an agreed overall rating, plus any mitigating actions required.

Board Assurance

All QIAs are specifically reviewed by the Medical Director and Nursing Director prior to consideration by EMT. Board assurance is achieved via direct Trust Board approval of the Plan, and also via external assurance review of CIP plans which will be undertaken by Deloitte in 2016/17, as it was in 2015/16.

In-year monitoring in 2016/17

The Trust operates a weekly Operational Requirements Group meeting chaired by the Chief Executive and involving senior managers from all parts of the Trust. This group monitors the achievement of CIPs, ensuring that QIA ratings remain valid in implementation. Additionally ad-hoc QIA panels are planned for 16/17 to ensure that new and revised CIP schemes undergo the same level of QIA whenever they are initiated throughout 16/17.



With all of us in mind

3.1 Approach to Workforce Planning

The Trust's Strategic HR Framework recognises the need to develop and re-design the workforce to ensure it is fit for purpose and sustainable. The framework has 3 key strategic HR work streams: Workforce Development and Planning; Staff Engagement and Wellbeing; Leadership and Management Development aim to ensuring we have the Right Staff in the Right Place at the Right time; Improve Quality; Improve Organisational Performance.

Workforce planning is an integral part of our service line planning process, to ensure they are developed by operational teams to reflect service needs and have clinical engagement. Changes in the workforce reflected in CIP or Cost Pressure plans go through a rigorous QIA process as is described in the 'Quality' section of this Plan. The QIA process includes Clinical Governance and Staff Side Input and the governance process is through the Executive Management Team to Trust Board.

Workforce change in 2016/17

Changes to our workforce arise from our transformation programme, our CIPs, our contract tendering activity and local and national investment priorities e.g. Early Intervention in Psychosis (EIP) and CAMHS. Specific instances reflected in our Plan are:

- Reduction in Family Nurse Partnership/ Health Visiting and School Nursing workforce as a result of commissioning intentions
- Reduced use of agency staff
- Reduced workforce re psychiatric liaison to reflect commissioning intentions
- Reduction in Health and Wellbeing posts as a result of commissioning intentions
- Reduction in management/admin resulting from CIP proposal



With all of us in mind

3.1 Approach to Workforce Planning - Continued

- Growth in EIP, and CAMHS Eating Disorders workforce as a result of investment and national focus
- Growth in forensic BDU workforce – secure estate CAMHS contract
- Growth in In-patient Establishment linked to Safer Staffing

The focus on enhancing quality and productivity of the workforce will include reducing Administration and Management costs through devolved decision making, implementing a lean approach to ward based and community based mental health and long term conditions services, and ongoing drive on agile working practices.

The re-design of the Clinical Support Workforce will see the extension of clinical apprenticeships as entry level roles, through to the development of Associated Nurses to optimise this key staff groups role in the care team. These new roles will improve quality and enable a reduction in agency nurse spend. They also provide a clearer career progression into professionally qualified nursing roles.

The Nursing Strategy identifies new specialist Nurse roles e.g. Advance Nurse Practitioners and Nurse Prescribers and these linked to development of Physician Assistants will support changes to the medical workforce.

Medical agency spend will be reduced over the next 12 months with recruitment of Consultants into a new Mental Health Acute and Community model of service where vacancies have been held pending change. In addition Speciality Doctor posts will reduce through a combination of replacing with more Consultant led services and introducing new non-medical roles as highlighted earlier, again this will also support a reduction in agency spend.



3.1 Approach to Workforce Planning - Continued

There will be significant challenges ahead to recruiting, retaining and developing a sustainable workforce. The Strategic HR initiatives for 16/17 will also include:

- Development of Wellbeing and Learning centre
- Development of collective leadership approach to support devolved decision making.
- Working across healthy economies on new role linked to Vanguard developments and system leadership
- Valued based Contracts of Employment and HR Policies, in addition to current Value based Appraisal, Recruitment and Induction.
- Staff Equality Networks and Breakthrough Programme

The Trust Board agreed new Leadership and Management Development, and Staff Engagement Strategies in 15/16 and there are on-going action plans for their roll out in 16/17 which includes:

- Leadership Competencies and Valued Based Leadership Behaviours
- Shadow Board Development Programme
- Wellbeing and Engagement Survey
- Middleground Programme to more closely connect first line manager roles to organisational strategy. This also supports the development of a coaching culture throughout the Trust.
- Staff Engagement Events linked to Service Transformation



With all of us in mind

4.1 Approach to Financial Planning

Financial Summary

There is an unprecedented level of financial challenge within the NHS. In this context, 2016/17 will be financially challenging for the Trust. The nationally set control total plus the impact of changes to National Insurance present a financial pressure of over 3.3% before any consideration of other cost pressures.

The Trust board approved the one year operational finance plan at the meeting on 29 March 2016. ***The approved plan presents a recurrent underlying surplus of £1.2m with an in-year planned surplus of £500,000.*** This planned surplus is lower than the control total of £1.2 million. Our approach to the control total is that we will endeavour to work towards the control total subject to the Trust Board being satisfied this is able to be delivered without compromising patient safety. Following the recent CQC review, the Trust has ***prioritised investment in safer staffing of £750,000*** to ensure continued safety of services which has directly affected our ability to deliver the control total. This position results in a Monitor I&E Margin rating of 3 for the Trust.

Approach to Financial Planning

The development of the financial plan is a Trust wide responsibility and as such we have ensured comprehensive engagement in the development of the plan. We have worked closely with service leads to ensure robust challenge in all cost improvement opportunities and cost pressures. The Trust Board have been fully engaged in the development of the financial plan and understand the unavoidable cost pressures for 2016/17 and the mitigations taken to address them. In addition our Members Council is actively engaged in the development of our plans. A workshop session on the 16/17 Operational Plan took place in March to inform the Trust Board's consideration of the Plan prior to approval at the March board meeting. We have also worked collaboratively with our main commissioners to ensure a joined up approach to financial planning and a joint understanding of the community financial position.



With all of us in mind

4.2 Financial Forecasts and Modelling

Income

For 2016/17 the income and expenditure account shows healthcare income is expected to be £210m which represents a small increase from the 2015/16 forecast outturn due to the positive 1.1% increase in national tariff. The surplus forecast assumes that all the CQUIN income will be achieved. Overall the income position for 2016/17 is assumed at £223 million. The reductions in local government funding are manifesting in challenging discussions with commissioners. Specific local challenges for example in relation to child health services have resulted in an assumed reduction in income within these services. Additionally our forecasts include reducing income in health and wellbeing services in line with public health investment.

Cost Pressures

Changes to National Insurance have resulted in an overall pay inflation of 3.3% (2.5% of total income). The impact of non recurrent achievement of 2015/16 CIP presents an additional cost pressure of £3.2 million in 2016/17. The Trust has undertaken a robust approach to challenging both cost pressures and cost improvement programmes between January and March 2016. Led by the Director of Finance, this process has involved challenge meetings with all BDU and corporate directors, panel meetings with the Deputy Chief Executive, Director of HR and Director of Finance and detailed review of all cost Improvements and Cost Pressures by the Trust Executive Management Team. Following this challenge process **the 2016/17 financial plan includes**

£4.4 million of cost pressures and developments; £3 million recurrent and £1.4m non recurrent with

highlights including:	Safer Wards & Staffing investment	£0.8m;
	Clinical staffing	£0.7m;
	Quality Academy staffing	£0.6m;
	Estates Strategy	£0.6m;



With all of us in mind

4.3 Efficiency Savings

Achievement of our planned surplus of £0.5 million means that we will need to deliver a challenging cost improvement in 2016/17. ***Our financial plan assumes a CIP of £10 million.*** All CIP initiatives are subject to a QIA assessment and significant programmes will be established with robust project management arrangements. The weekly Operational Requirement Group has responsibility for ongoing review and assessment of CIP delivery. Significant areas of our CIP are in direct response to the recommendation in the Carter Productivity Review:

- Productivity review of Older People and Community Services;
- Comprehensive review of Trust Management Costs;
- Extensive review of Trust non pay contracts through effective re-procurement of services;
- Review of contracts for pathology and radiology;
- Review of prescribing and medicines management to reduce Trust drug costs;

In addition, we are undertaking a focused review of Trust services to maximise the benefits of service standardisation across our geography; a comprehensive review of all service and support budgets; development of a peripatetic staffing pool to minimise the reliance on agency staff with the Trust; and reduction in out of area placements.

Our CIP programme has been assessed by our external auditors to give the Trust independent assurance on the quality and achievability of the Cost Improvement Programme. The findings of this work have been shared with the board prior to submission of the plan. This is a very challenging year for the Trust financially and the achievement of the surplus is predicated on delivery of £10m CIP and £2 additional contract income, which reflects a risk mitigated application of national planning guidance. In the last 5 year plan submitted 2016/17 was identified as the last year in which the Board could sign off the organisation's sustainability in current form.



With all of us in mind

4.4 Efficiency Savings

Lord Carter Review

The review of operational productivity by Lord Carter published in February 2016 highlighted a wide range of areas where efficiencies can be delivered in NHS Provider organisations. Although specifically directed acute providers many of these areas are applicable to mental health and community providers and have informed many of the Cost Improvement Programmes included within the 2016/17 plan.

- Medicines optimisation: Improved management of stocks;
- Re-procurement of drugs supplies;
- Rationalisation of Trust processes
- Pathology Services: Re-procurement of pathology services
- Procurement: Detailed programme to maximise efficiencies
- Corporate Costs: Robust trust wide admin review
- Estates Utilisation: Ongoing review of Trust estate

Admin/Management Review

A key element of the CIP programme for 2016/17 is a robust review of the administrative and management costs within the Trust. In line with the findings from the Carter report the Trust recognises the need to reduce the amount of its budget spent on management costs and has set a target to reduce costs in 2016/17 by 5%.

Agency Staff

The Trust has been advised of an overall ceiling of £5.1 million for agency costs. We have plans to undertake a competition through the NHS framework to secure greater efficiency in agency rates. The application of the caps on rates will not directly support the CIP programme but will minimise in year cost pressures resulting from the use of interim staff and support delivery of the ceiling.



With all of us in mind

4.5 Capital Planning

Clinically and operationally led capital investments

The capital programme is driven by the clinical strategy. All business cases focus on clinical quality, safety and efficiency. E.g. the re-development of mental health inpatient wards at Fieldhead Hospital will enable greater efficiency through co-working across units; added flexibility in bed usage to achieve optimal bed occupancy and flexibility of service delivery; significantly upgrade the environment experienced by Service Users; and will ensure full compliance with privacy and dignity standards.

Prioritisation of capital investments

Each scheme is evaluated at the Trust wide Estates TAG which combines clinical governance, operational, financial and estates perspectives. We analyse return on investment and alignment with both clinical and business strategies. Every major scheme has a full business case which must be approved by Executive Management Team and all schemes over £500,000 are also approved by Trust Board. In this way the Board derives assurance of prioritisation, alignment, and value for money. All minor schemes undergo a rigorous pre approval process through TAG before approval by EMT to ensure best value. All schemes have to meet the test of improving clinical efficiency or resolving safety issues in order to be approved.

Making best use of NHS estate

The Trust is currently adopting the NHS Premises Assurance Model which brings together compliance with quality and safety standards and efficiency. We actively manage our assets in line with the recommendations of our Estates Strategy. This includes significant rationalisation of our community estate, driving efficient utilisation of both owned and leased retained assets, and focused investment on the strategic core sites.

Opportunities for consolidation and disposal of significant sites in Castleford and Barnsley are expected to realise capital receipts during the next two years. A corresponding programme of Investment in integrated locality hub facilities is underway with Hubs opening this year in Wakefield and Pontefract. This is also supported by continued investment in technology and behavioural change to enable agile working.



With all of us in mind

4.5 Capital Planning

Major Schemes for 2016/17

The capital programme has been reviewed to ensure that capital expenditure is only being used where required and to ensure that all schemes are clearly focused on improving safety and quality, and enabling efficiencies to be made through disposals. In line with our longer term strategy the schemes reflect a commitment to visible and accessible community based delivery, and high quality, safe and effective in-patient services with an excellent user and visitor experience. The schemes for the year ahead are;

Scheme	Narrative
Pontefract Hub	Community based local delivery hub and meeting space for agile workers. This supports disposal of surplus assets.
Wakefield Hub	As above
Fieldhead Wards (Non Secure)	This work is necessary as part of our ongoing commitment to ensuring mental health wards are safe, welcoming, therapeutic and efficient to operate now and in the future.
Upgrade Airedale Health Centre	Enabling further agile working potential and also enabling asset disposal
Fieldhead Master Plan	Optimising effective use of one of our main sites, enabling closer joined up working between teams and facilitating disposal of assets/ termination of leases elsewhere
Bretton	Completion of refurbishment of Forensic Wards to ensure a safe and effective operating environment



With all of us in mind

5.1 Links to Sustainability & Transformation Plans

SWYPFT primarily operates across five local CCG areas in West and South Yorkshire (Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield) with some service provision into localities beyond this core territory. Additionally SWYPFT is a major provider of secure mental health services for the whole Yorkshire region. As such we contribute to many place based and wider collaborative planning exercises.

In our strategy we have stratified our service lines into four tiers dependant upon the footprint and types of partnerships that we believe are necessary to secure the sustainability of those services. The STP planning process and localised place-based planning exercises give us an opportunity to test this thinking with commissioners and other provider partners. Our strategic tiers are as follows:

Specialised Commissioning Forensic – clinical network/consortium Successful in national procurement . Open additional beds Year 2 expand scope of service through tendering activity and sub specialisation plus CAMHS.

Core NHS Mental Health Regional Services – Consolidation of Urgent care pathways / Specialist services / CAMHS / Memory services and LD on sub-regional footprint.

Local CCG Footprint - Use PbR to focus and streamline specialist offer with substitution from specialist to third sector/primary care alternative offer. Work on integrated locality teams – synergy in physical/mental/ social care model

Enabling communities - key partnership with Primary care Local Authorities and Public Health by reducing use of statutory services, create capacity in Primary Care through substitution to alternative cheaper capacity which creates social capital and self directed support e.g. recovery colleges, Creative Minds, Altogether Better.



With all of us in mind

5.2 Links to STPs: New Models of Care

- Sustainability and transformation planning builds upon several local **Vanguards** in which we are participants:
- **Calderdale MCP** – into which we are planning; support for mental health liaison into multi-disciplinary locality teams, clearer links between mental health and physical health ‘first point of contact’, and building capacity around Creative Minds and Recovery Colleges to support social prescribing/ well-being plans
- **West Wakefield MCP** – into which we are providing; health and wellbeing support which is reducing GP attendances, and mental health navigators in locality hubs. A telehealth coaching pilot is also proposed.
- **Wakefield Care Homes Vanguard** – into which we are part of a dedicated MDT supporting the needs of care home residents to promote person centred care using our Portrait of a Life e-learning package
- **West Yorkshire Urgent and Emergency Care Vanguard** – best use of acute mental health bed base, development and refinement of crisis care arrangements including police liaison and psychiatric liaison working in partnership with the two other mental health trusts in West Yorkshire.
- In addition we are active participants in work in Barnsley to apply MCP principles, starting with Respiratory and Diabetes pathways. In Barnsley there is a clear direction of travel towards Accountable Care System, and this sits in the context of the emerging **South Yorkshire and Bassetlaw STP** footprint and the **South Yorkshire Hospital Chain Vanguard** in which our local provider partners Mid Yorkshire Hospitals Trust and Barnsley Hospital Foundation Trust are participants. In our medium term scenario planning we have started to model the potential impact of these developments.
- The **West Yorkshire STP** thinking for mental health is closely aligned to the Urgent Care Vanguard which covers West Yorkshire (described above). We are working with CCG and local authority colleagues across the Calderdale, Kirklees, and Wakefield geography to align this with local place based planning. Additionally we are supporting place based work in North Kirklees with partners including the local GP Federation to apply MCP principles to find the best way to serve the needs of the local population. Our CEO will lead the West Yorkshire STP work.

6. Membership and Elections

Membership strategy and supporting diversity

The Trust's approach to membership and engagement is set out in its Involving People, Working Together, Being in Control Strategy, which is about all of us working together to improve and develop our services for the benefit of everyone. In summary, membership of the Trust means local people have a greater say in how services are provided in the areas the Trust serves, and that services take account of local needs. The Trust encourages people to take a special interest in our services, using membership as an opportunity to shape the future of health care in our areas. Membership is free, with few specific requirements (subject to the legal exemptions on eligibility and the Constitution of the Trust), has a lower age limit of 11 and no upper age limit, and service users and carers are included in the public constituency. Our public constituencies reflect our geography in proportion to the population of each area and, although we aim to retain a membership of 1% of the populations we serve, the key focus is to encourage members to be engaged and involved with our Trust.

The Trust evaluates progress in membership recruitment through comparison of membership with local population demographics, which allows a focus on areas of under representation. The Trusts membership plays a vital role in helping the Trust to shape its services. Key areas for the next 12 months are:

- involvement in CQC focus groups, driving up the quality of services through feedback;
- election of Governors to our Members' Council, ensuring sound governance arrangements;
- involvement in Customer Service Excellence Accreditation, helping shape an enhanced patient experience;
- input to transformation work streams, shaping future services to ensure they are fit for purpose;
- service visits through 15 steps programme, ensuring a patient-centred approach to care.



With all of us in mind

6. Membership and Elections

Our Members' Council

Our Members' Council is made up of elected representatives of our members and staff, and also nominated members from key local partner organisations such as local NHS Trusts, Local Authorities and the University of Huddersfield. We currently have 34 governors, 18 public, 7 staff and 9 appointed. The Council's role is to make sure that the board of directors, which retains responsibility for the day-to-day running of the Trust, is accountable to their local communities through holding the non-executive directors to account for our performance.

Governor elections

The Trust holds elections each year to reflect the vacancies on its Members' Council in accordance with the Trust's Constitution. The elections are managed for the Trust by the Electoral Reform Services (ERS).

Governor support and development

The Trust works with ERS to publicise its elections and to encourage members to stand for election. The Trust is currently reviewing its approach to the training and development of governors to reflect governor feedback and we are planning to use the newly published induction support from NHS Providers, tailored as applicable, to support the induction of new governors from May 2016.

There are a number of activities to facilitate engagement between governors, members and the public, including the annual members' meeting and Insight events for members, which include opportunities for members to meet and talk to our governors. Our Members' Council also helps us shape future strategy and is directly engaged in the development of the Annual Plan, most recently through a joint workshop with Trust Board on priorities held in February 2016. Governors also play an important role in issues such as quality, equality and involvement, and development of our Quality Accounts through the Members' Council Quality Group.



With all of us in mind



With all of us in mind

SWYPFT Annual Plan 2016/17

Appendix 1

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

Key Financial Metrics				
	Forecast 2015/16		2016/17 Plan	
EBITDA	9,897	4.4%	8,980	4.0%
Surplus / (Deficit)	207	0.09%	500	0.2%
Surplus - Recurrent			710	0.3%
CIP	8,333	3.78%	10,059	4.7%
Cost Pressures			4,403	2.1%
Capital	11,289		12,313	



With all of us in mind

SWYPFT Annual Plan 2016/17

Appendix 2

Annual Plan Position 2016/2017

	15/16 FOT	2016 / 2017		
	Total	Rec	Non Rec	Total
Healthcare Income	209,622	209,682	0	209,682
Other Income	16,900	13,256	0	13,256
Total Income	226,521	222,938	0	222,938
Pay	(171,463)	(167,572)	(431)	(168,003)
Non Pay	(45,161)	(46,175)	221	(45,955)
Total Expenditure	(216,624)	(213,747)	(210)	(213,958)
EBITDA	9,897	9,190	(210)	8,980
Capital Charges - Depreciation & PDC	(9,556)	(8,555)		(8,555)
Interest	89	75		75
Estates Impairment	181	0		0
Estates Revaluation	2,743	0		0
Restructuring & Re-organisation	(3,147)			0
Surplus / (Deficit)	207	710	(210)	500

EBITDA as percentage of Operating Expenditure	4.6%
Surplus as percentage of Income	0.1%

4.2%
0.2%

Members' Council

6 May 2016

Our transformation programme



With all of us in mind

Transformation Programme

- Acute and Community Mental Health
- Mental Health Rehabilitation and Recovery
- Older Peoples Mental Health
- Learning Disabilities



With all of us in mind

Acute & Community Mental Health

To enable people to reach their potential and live well in their community

- Safe and person centred
- Encourage greater control for individuals
- Emphasise recovery and positive outcomes

To deliver care to services users in a more effective and efficient way

- Improve quality at reduced cost
- Increase links to alternative community based services, promoting partnership working
- Optimise the use of technology
- Use evidence based best practice

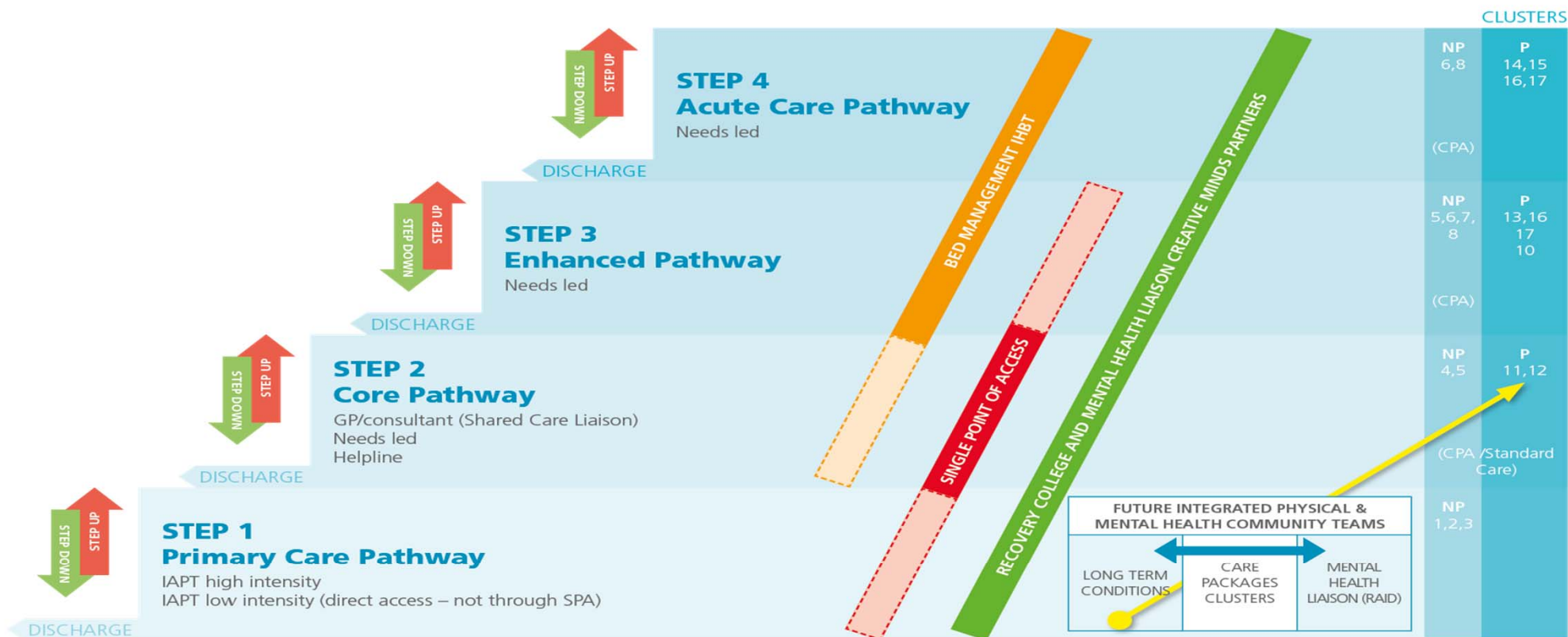
Our aim is to be a leading provider of recovery-focused mental health care that is developed in partnership with people and delivered in their own homes

- Enhancing our community services so that we can care for people in or close to their homes wherever possible
- Providing timely diagnosis and prescribing, so that hospital admissions are a last resort
- Working to reduce the number of hospital beds so that we can invest more in community services, while making sure that beds remain available for all people who urgently need them
- Making sure that people in hospital receive high quality care which helps them to return home as soon as possible



With all of us in mind

Acute & Community Mental Health



With all of us in mind

Acute & Community Mental Health

The Core Pathway

- intended for people with moderate to severe mental health conditions who require a less complex package of care
- May only require brief or short-term mental health intervention, or may require longer-term contact with mental health services during a period of stability
- Core Pathways teams will work with GPs, social care providers and other partners to build shared understanding of service pathways
- Ensure that referrals go directly to the right team so service user's needs are met in a timely and efficient manner
- Simpler and more integrated access for people and their GPs
- Fewer repeated assessments and hand-offs between teams
- Enhanced communication between services
- More flexibility to respond to needs



With all of us in mind

Acute & Community Mental Health

The Enhanced Pathway

- Use the Flexible Assertive Community Treatment (FACT) model of care to provide responsive support for people with severe and enduring mental health conditions.
- CPA care coordination and multi-disciplinary team approach for most people
- Where needs increase temporarily we will provide a flexible period of intensive contact and support by the team that the person is familiar with (10% – 20%)



With all of us in mind

Acute & Community Mental Health

Progress

- New Standard Operating Procedures have been agreed with all teams
- Engagement of staff-side and social work colleagues prior to the start of formal consultation
- Workforce models developed including sign-off of generic job descriptions in collaboration with staff side
- Staff consultation underway. In May transition to new roles expected to start
- Financial costing of current and proposed models to evidence cost savings

Next steps

- Implementation events and initial implementation of new service model in Q1 2016.



With all of us in mind

Mental Health Rehabilitation

Our aim is to ensure the Trust's rehab and recovery services support people needing longer term rehabilitation support as part of their recovery to live in their own community as far as possible. Where specialist in-patient facilities are required these should be clearly focused on recovery and as close to home as can be achieved within efficiency and quality parameters

- Enhancing our community rehabilitation services so that we can care for more people in their own home in their community
- Working with commissioners and other providers to extend the range of accommodation and support options available to people locally
- Re-focusing our in-patient mental health rehabilitation services to enable more people to return from out of area placements, and supporting timely discharge from acute wards



With all of us in mind

Mental Health Rehabilitation

Progress

- Practical change in Wakefield locality with closure of Castle Lodge facility and enhancement of local community teams to better support people in their own homes
- Review and assessment of needs of people from Kirklees who are in and out of area at present, with more people returning to their communities with appropriate support packages in place. Part of a longer term partnership with commissioners
- Development of new workforce structures and service model for each BDU, plus financial costing of current and proposed models to evidence cost savings, and engagement of staff-side and staff

Next steps

- Continued clinically led conversations with commissioners in all localities to ensure full pathways are developed and resourced



Older Peoples Mental Health

Progress

- New integrated models of dementia diagnosis and support being put in place. Care Closer to Home integration in Kirklees, Pilot in Barnsley etc
- Discovery into older peoples community and in-patient services – productivity opportunity – development of alternatives to admission?
- Conversation with partners – e.g. role of primary care and support from us
- Agreement to proceed to design future models

Next steps

- Test productivity assumptions – use gain to develop intensive home based treatment type offer, which in turn should allow more effective use of bed base



With all of us in mind

Learning Disabilities

Our aim is to provide timely and effective specialist health services for people with learning disabilities who need extra help to live safely and well

- With greater emphasis on community support and flexibility

Progress

- New models of care tested and agreed with partners including people who use our services and staff who work within them
- Completion of changes to bed base – two sites into one specialist unit
- Alignment with local Transforming Care Plans and with national drive to help more people to leave institutional settings and live independently
- Staff consultation completed and staff moving into new roles. Further recruitment underway where required

Next steps

- Implement new models, celebrate successes and use learning to continue improvements as we go



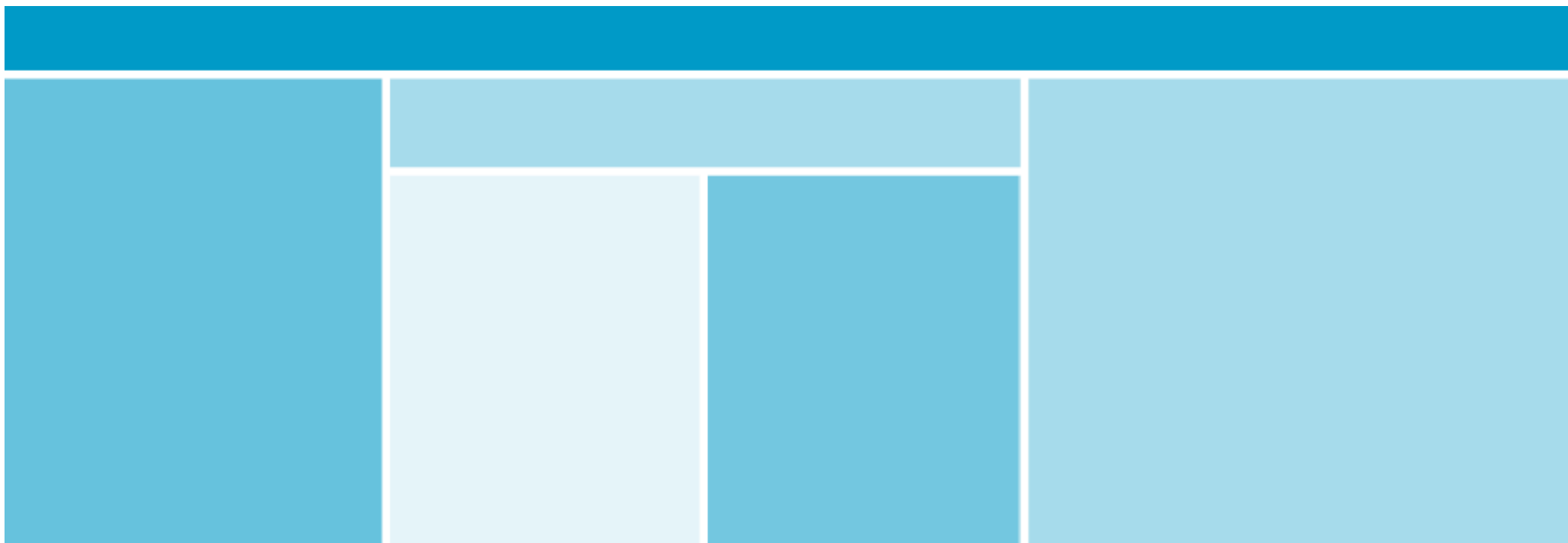
With all of us in mind



With all of us in mind

Quality Performance Report

Strategic Overview



March 2016

Table of Contents

	Page No
Introduction	4
Quality Headlines	5 - 6
Compliance	7 - 8
Strategic Overview Dashboard	9 - 10
Finance - Overall Financial Position	11
Contracts - Trust - BDU	12
MH Currencies Development	13 - 14
Workforce	15 - 17
Publication Summary	18 - 19
Glossary	20

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for March 2016 information unless stated. The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

1. Feedback from managers following incident reviews/investigation

Patient safety support team have developed and tested the facility on Datix to provide feedback to staff who reported an incident. This will be live before the end of April. Staff who report incidents will be able to choose to receive feedback following the review by the manager when the incident is finally approved. If an investigation is still ongoing staff will be informed of this and given the managers name to contact for further update.

2. Infection, prevention and control

The annual plan 2015-16 has progressed well. Positive work has been undertaken throughout the year. There were 71 objectives, 68 have been completed 3 are in progress. All 3 are audits that have been undertaken; the data has been collated, awaiting reports and subsequent action plans.

- 2016-17 Annual Plan has been approved at IPC TAG.
- Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 6. End of year total 3 cases, all scrutinised through the Post Infection Review (PIR) group and deemed unavoidable.
- Mandatory training- Hand Hygiene training - trust total- 90%
- Infection Prevention and Control- trust total – 88%
- Participating in PLACE audits throughout the trust.
- Save Lives: Clean your hands- WHO's global annual call to action for health workers, will be on the 5th May 2016.

3. NMC assurance visit

The NMC recently visited a number of clinical areas/practice placements within SWYPFT as part of their Quality Assurance monitoring of the undergraduate nursing courses at University of Huddersfield. Reviewers commented on strong partnerships, good risk management strategies, good service user and carer involvement and considerable investment in the support of nursing mentors. They concluded that effective Quality Assurance processes were in place, supported by Practice Learning Facilitators and consequently all outcomes were met.

4. Revalidation

We have developed a presentation and workshop to train staff and their managers/confirmers in revalidation and the requirements, to date over 300 people have attended. We have also developed a website on the trust intranet with all resources required. We have worked closely with colleagues in workforce to ensure systems support (e.g. alerts are sent to registrants to remind them) and have met with colleagues in Learning and Development to look at how appraisal might support and we are working on some potential options. There are 2 people seconded until June 2016 to lead the process and they have managed to steer first 20 nurses through in April 2016 using a case managed cohort approach.

Lots of lessons learned and even with very clear systems, training, reminders and intensive support of project leads, some people appear to struggle to engage with the process. Colleagues in workforce reported that this was not unusual and every month, under current (much simpler) system of re-registration, we usually have a couple of registrants who either fail to reregister or leave till very last minute.

5. Safer staffing

There remains a concern about staffing on the acute wards in Wakefield. Work is ongoing, led by the BDU in partnership with the nursing, AHPs and Clinical Governance Directorate to address and resolve the issues. This includes shift planning and support from the Safer Staffing Project Manager. Additionally the acute wards have been provided with the first four peripatetic HCSW's.

Recruitment – there is an ongoing Trust wide Band 5 recruitment Drive. Currently we have held 3 assessment centres resulting in 37 successful candidates being offered posts. The recruitment drive continues and we are actively engaging in university careers fairs and planning an open day.

6. Innovation factsheets

As part of the preparation for the CQC inspection we produced a number of factsheets and innovation briefings, these are bite size pieces of information that give an overview of what we have done to improve the quality of care. Briefings can be found on the trust intranet. We have received very positive feedback on the factsheets.

7. Physical health care in mental health and learning disability services

46% of people with mental health problems or learning disabilities also have long term physical health problems (King's Fund, 2012). It's vital we look after the whole person. We have established a programme of work to address this need.

Achievements to date

- We have audited the physical health examination undertaken by medical staff during the admissions process and found some good results.
- We have audited the physical health monitoring of people who have been prescribed antipsychotic medications looking for baseline measurements and ongoing monitoring again found good areas of practice.
- The guideline document on physical health care is in use trust wide and has received positive feedback from services and clinicians.
- A pilot is in situ on the Fieldhead site looking at the use of the Bradford Physical health model with particular emphasis on ECG measurements using state of the art equipment.
- RAMPPS training is being actively pursued with the creation of the Physical Health Training facility in L&D FHH.
- Proposed future work involves developing a Physical Health Policy and rolling out of the Bradford Physical Health Model across the trust.

8. Information Governance

82 IG incidents were recorded across the Trust during the quarter, which represents a 32.3% increase on the previous quarter. This increase in incidents remains a concern and a plan to mitigate the risks is in place.

An IG SIRI was notified to regulators in January when sensitive information about a child was disclosed in error to the birth mother of a fostered child and allegedly later posted on social media. The investigation into the employee responsible for the error has now been completed and the first draft report will be available shortly.

9. Enfield Down

Recent visit by CQC has triggered an action plan to develop the following improvements

1. Medical time enhanced and evenly spread across the week
2. Psychological Therapies enhanced with future position identified
3. Physical Health interventions improved – a no of options to pursue
4. Clinical Leadership structure redesign
5. Band 6 focus on the pillars of governance

All actions to improve access to Mental Health, Physical Health and Psychological Services to enhance individual well -being which supports their rehab programme for step down, step up.

Clinical leadership will focus on clinical outcomes, ensuring the workforce is fit for purpose to deliver the rehab and recovery service.

10. Health of Children in Care

A number of areas have been worked on this year in partnership with our local authority partners and the CCG. Actions were identified from CQC inspections and lessons learned from a serious case review.

What difference have these actions made?

- Better use of the Strengths and Difficulties (SDQ) both within individual health assessments and data collection to identify themes and trends.
- Health professionals that undertake LAC health assessments have received training to support competency requirements recommended in the Looked after Children: Knowledge, skills and competences of health care staff.

INTERCOLLEGIATE ROLE FRAMEWORK March 2015

- Young people's right to consent or dissent is supported and upheld.
- Information from a wider range of health provision is used to inform health assessments.
- There is closer timely monitoring of health assessments and any concerns are escalated including to the CCG when appropriate.
- Children and young people placed out of Barnsley are not disadvantaged in terms of their health needs.
- The Service Specification for Children in Care and Care Leavers has been reviewed by the CCG, to ensure it remains appropriate in light of new statutory guidance. They have also liaised with Public health to ensure LAC provision is considered within the new commissioning arrangements for 0-19 children's community services.

11. MHA/MCA action plan

As part of the CQC inspection we submit our action plan for the MHA code of Practice. The outstanding amber actions are placed within the relevant BDU's and TAG's. The action plan is on the agenda for the MHA committee in May 2016

12. Junior Doctor industrial action

To date the industrial action taken by junior doctors has had a minimal impact to our planned services. This is expected position for future action.

13. RIO

We continue to experience ongoing issues with RiO. The team continue to work with Servalec to address the problems and resolve issues as quickly as possible.

14. Risk panel goes live

We have enhanced our weekly risk scan and commenced a risk panel attended by the Medical and Nursing Directors to assess and make recommendations in response to clinical risks impacting on the Trust arising from serious incidents reported on datix.

The panel will fulfil a number of functions including

- Review of red and amber serious incidents (Sis) reported on DATIX in previous week and
- Contributing to the terms of reference for SI reviews
- Commission reviews and/or advise on objectives for reviews of amber incidents and/or clinical reviews as required
- Identify where themes or trends emerge following the reviewing of incidents
- Advise on remedial actions if required
- Review intelligence from within and outside the Trust

15. Children's services exit strategy and risk

SWYPFT are working to ensure a smooth transfer of staff following the decision by SWYPFT to withdraw from the provision of Barnsley's 0-19 healthy child programme commissioned by Barnsley MBC

What have we done?

- Following months of negotiation with BMBC, SWYPFT's Board took the difficult decision to withdraw from this contract as no clinically safe model could be agreed upon within the resources available.
- Briefings have been held with staff affected and Staffside colleagues kept informed.
- HR currently working on TUPE
- Internal Transformation team formed to undertake actions prior to and during transfer to new provider. Meetings held on a weekly basis regarding transfer and continuity of service provision.
- Director level weekly programme dial in meeting held with Senior colleagues at BMBC, to raise actions/issues etc.

16. Horizon action plan

Following a number of concerns relating to practice at the Horizon Centre in 2006, 2013 and 2014, SWYPT commissioned an independent review in order for the concerns to be explored in detail and to seek assurance relating to practice and culture in accordance with its vision, values and national standards. In response a number of concerns were highlighted and a comprehensive and detailed action plan has now been put in place supported by senior managers in the Trust and the service commissioners.

17. Management of aggression and violence

The trust took part in NHS Benchmarking Network's national exercise and our performance overall in relation to patient to patient violence and violence against staff is better than sector average as is use of restraint overall. Some individual areas were above the average for their sectors in that month. We are aware that overall our figures for violence against staff and patient on patient have increased this year but we are still below average for both areas when weighted.

1. CQC Inspection

The Trust received a formal CQC inspection under the new framework in March 2016. Initial verbal feedback from the visit has been received by the trust, with the final report being expected early May 2016. When we are awarded our rating from the CQC we are required to display them in each and every premise where regulated activity is delivered, in our main place of business and on our website. The CQC guideline also encourages Trusts to raise awareness of ratings when communicating with people who use our services, by letter, email or other means.

2. CQC regulation fees

As the CQC is required to reduce the funds it receives from central finances the costs are being recouped from the services it regulates. Throughout 2015/16 the CQC have made

3. CQC Strategy 2016-2021

In March 2016 the CQC published a consultation document: Shaping the future (CQC's strategy 2016 to 2021). This document sets out how they propose to deliver their vision by becoming a more efficient and effective regulator. There are 6 themes to the review which may collectively have potential risks we need to consider and mitigate against. The themes are:

- improving use of data and information;
- implementing a single shared view of quality
- targeting and tailoring inspection activity
- developing a flexible approach to registration
- assessing how well hospitals use resources
- developing methods to assess quality for populations and across local areas

Should these proposals be accepted early identifiable potential risks may include:

- the increased importance of correct and complete clinical information
- increase in whistleblowing alerts and subsequent investigations
- contribution to a new data set in a move away from intelligent monitoring to 'CQC insight'
- all quality reporting to be aligned to the CQC 5 key domains framework (both at national and local level)
- increased regulatory scrutiny of services that receive ratings of either requires improvement or inadequate in any of their core services/ teams.

4 CQC Intelligent Monitoring

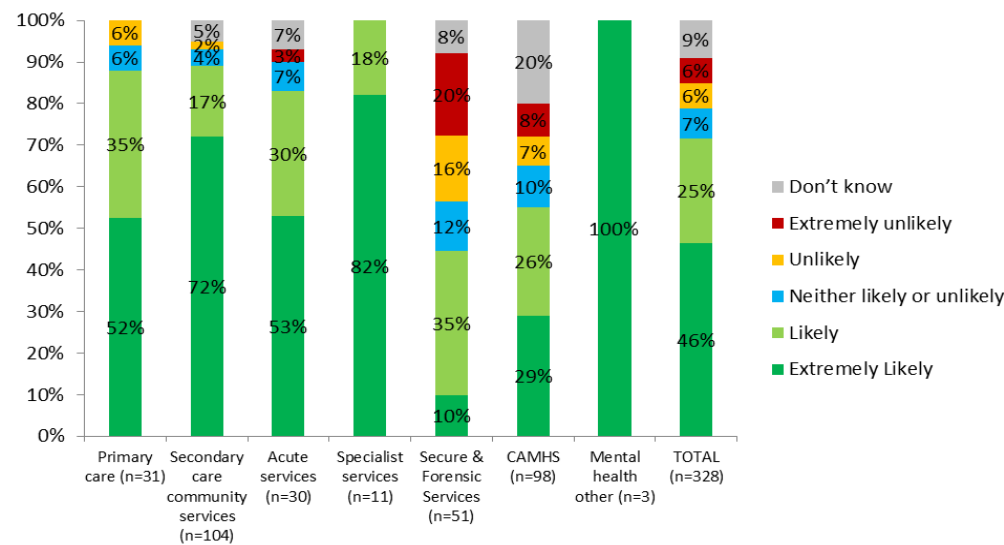
In February 2016 the Trust received the latest CQC Intelligent Monitoring report, which is a report the CQC has developed for monitoring a range of key indicators about Trusts that

Patient experience – Trust FFT scores (heading)

The trust has adopted the FFT as its quality measure for patient experience as this is the one consistent question that is asked across all services. March results can be seen on the chart 's below:

Mental Health

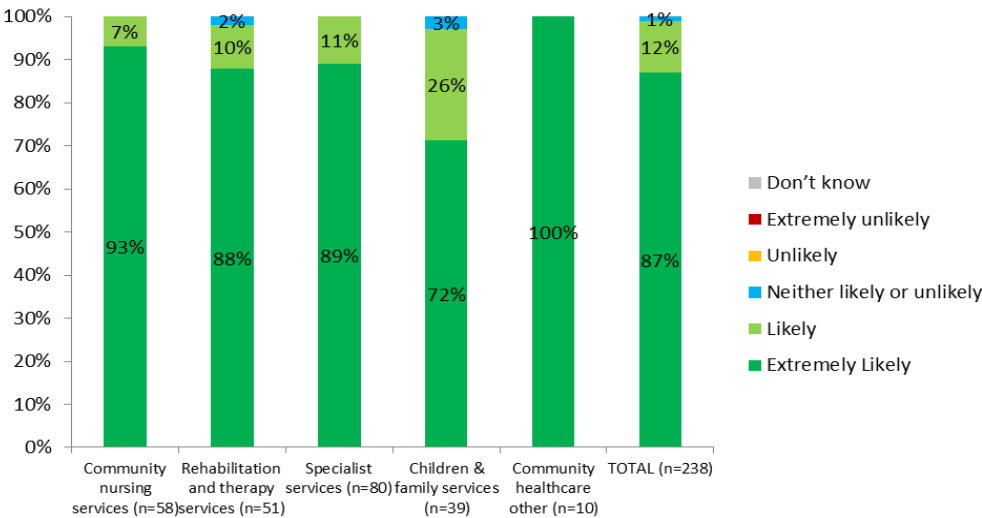
Number of unique patients accessing services during the month: 13735



71% would recommend mental health services, 12% would not.

Community Services

Number of unique patients accessing services during the month: 19919



99% would recommend community services, 0% would not.

Strategic Overview Dashboard																							
Business Strategic Performance Impact & Delivery																							
1	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position	
2	Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4	
3		Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4	4	4		4	
4	CQC	CQC Quality Regulations (compliance breach)	CQC	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4	
5	COUIN	COUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G		3	
6		COUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G		3	
7		COUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G		3	
8		COUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G		3	
9		COUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Green	Green	Green	Amber/G		3
10	Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	6	0	0	0	2	1	0	0	0	0	0	0	0	0	3	0	0		4	
11	C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		4	
12	Outcomes	% SU on CPA in Employment	L	10%	6.55%	7.34%	7.18%	6.97%	7.38%	7.55%	7.68%	7.32%	7.37%	7.17%	7.25%	7.05%	7.18%	7.55%	7.37%	7.25%			
13		% SU on CPA in Settled Accommodation	L	60%	60.27%	65.26%	64.44%	57.79%	60.34%	62.81%	64.46%	63.39%	64.09%	63.56%	62.26%	61.34%	64.44%	62.81%	64.09%	62.26%			
Customer Focus																							
14	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position	
15	Complaints	% Complaints with Staff Attitude as an Issue	L	<25%	12% 8/66	14% 6/44	13% 9/69	12% 9/73	12% 5/42	15% 6/41	12% 5/42	16% 9/58	15% 6/40	7% 4/57	13% 10/74	21% 17/80	14% 23/179	13% 20/156	14% 20/140	15% 31/211		4	
16	Service User Experience	Friends and Family Test	L	TBC	89.00%	92.00%	87.00%	93.00%	89.00%	91.00%	88.00%	85.79%	93.51%	89%	88.00%	93.00%	89.00%	91.00%	88.83%	87.20%			
17	MAV	Physical Violence - Against Patient by Patient	L	14-20	Above ER	Above ER	Above ER	Within ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER		4	
18		Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER		4	
19	FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100% 24/24	100% 17/17	100% 24/24	100% 28/28	100% 20/20	100% 25/25	100% 19/19	100% 13/13	100% 19/19	100% 23/23	100% 23/23	100% 29/29	100% 65/65	100% 73/73	100% (51/51)	100% 75/75		4	
20	Media	% of Positive Media Coverage Relating to the Trust and Its Services	L	60%	92.00%	92.00%	92.00%	80.00%	75.00%	50.00%	40.00%	50.00%	Data avail month end	Data avail month end	Data avail month end	Data avail month end	92.00%	68.00%	Data avail month end	Data avail month end		4	
21	Befriending services	% of Service users allocated a befriender or volunteer led group support (gardening/music/social) within 16 weeks	L	70%	50.00%	50.00%	50.00%	20.00%	20.00%	100%	100%	100%	100%	100%	100%	100%	50.00%	20.00%	100%	100%		4	
22		% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4	
23		% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4	
Operational Effectiveness: Process Effectiveness																							
24	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position	
25	Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	99.11%	100%	99.86%	100%	99.32%	98.60%	99.86%	97.64%	100%	97.91%	95.43%	97.41%	99.70%	99.28%	99.18%	96.90%		4	
26		Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	98.06%	97%	99.82%	100%	97.31%	99.16%	98.92%	97.58%	100%	100.00%	97.86%	95.81%	98.35%	98.76%	98.80%	98.11%	93.10%	4	
27		Delayed Transfers Of Care	M	750%	2.69%	1.64%	2.06%	1.96%	1.70%	1.80%	3.49%	2.89%	2.42%	2.31%	2.23%	2.46%	1.83%	2.73%	2.73%	Data avail month end		4	
28		% Admissions Gatekept by CRS Teams	M	95%	83.26%	96.30%	97.20%	100%	95.90%	96.12%	95.49%	95.90%	96.77%	99.06%	95.88%	100.00%	95.51%	97.29%	95.69%	98.32%		4	
29		% SU on CPA Followed up Within 7 Days of Discharge	M	95%	98.21%	100%	97.86%	97.70%	95.35%	100%	95.39%	95.60%	95.95%	97.73%	97.52%	97.33%	98.66%	97.97%	95.50%	97.44%	96.90%	4	
30		% SU on CPA Having Formal Review Within 12 Months	M	95%	96.37%	95.18%	97.92%	96%	88.57%	98.44%	86.88%	97.52%	98.56%	98.32%	96.72%	96.60%	97.92%	98.44%	98.56%	96.60%	97.67%	4	
31		Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	108.97%	102%	104.60%	147.59%	108.97%	113.25%	83.42%	99.48%	102.51%	96.15%	83.85%	94.14%	104.60%	113.25%	102.51%	84.14%		4	
32		Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100%	100%	100.00%	100.00%	100.00%		4	
33		Data completeness: comm services - Referral information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
34		Data completeness: comm services - Treatment activity information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
35		Data completeness: Identifiers (mental health)	M	97%	99.70%	100%	99.62%	100%	99.62%	99.54%	99.65%	99.55%	99.45%	99.25%	99.82%	98.48%	99.62%	99.54%	99.45%	98.48%		4	
36		Data completeness: Outcomes for patients on CPA	M	50%	78.83%	79.07%	77.63%	78.67%	77.64%	76.97%	78.40%	77.94%	78.58%	78.13%	76.84%	75.58%	77.63%	76.97%	78.58%	75.58%		4	
37		Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant	
38		IAPT - Treatment within 6 Weeks of referral	M	75%	81.46%	76.52%	75.72%	73.70%	75.83%	77.98%	75.31%	72.28%	65.66%	70.06%	70.04%	71.42%	77.84%	75.91%	71.62%	70.51%			
39		IAPT - Treatment within 18 weeks of referral	M	95%	98.60%	98.90%	99.74%	99.09%	98.89%	99.38%	99.38%	99.67%	99.10%	98.15%	97.47%	97.50%	99.09%	99.15%	99.37%	98.09%			
40		Early Intervention in Psychosis - 2 weeks (NICE approved care package)	M	50%	40.00%	81.82%	58.33%	56.25%	55.56%	80.00%	66.67%	84.60%	See below for new criteria.										
		Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Clock Stops		50%	National reporting commenced Q3.								85.19%	90.91%	88.24%	73.33%	National reporting commenced Q3			85.19%			
		Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Waiting at month end		50%	National reporting commenced Q3.								25.00%	93.75%	60%	60%	National reporting commenced Q3			25.00%			
43	Data Quality	% Valid NHS Number	C (FP)	99%	99.87%	100%	99.88%	99.71%	99.58%	99.76%	99.58%	99.30%	94.11%	99.58%	99.65%	Avail Next Month	99.88%	99.68%	97.66%	Avail Next Month		4	
44		% Valid Ethnic Coding	C (FP)	90%	99.05%	95%	94.86%	94.88%	94.90%	94.83%	94.73%	94.12%	99.31%	99.62%	94.59%	Avail Next Month	96.28%	94.87%	96.05%	Avail Next Month		4	

Strategic Overview Dashboard

Fit for the future Workforce																						
Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position	
Sickness	Sickness Absence Rate (YTD)	L	4.4%	4.80%	5.10%	5.00%	4.80%	4.80%	4.90%	4.90%	4.90%	5.00%	5.00%	5.00%	5.00%	5.00%	4.90%	5.00%	5.00%		1	
Appraisal	Appraisal Rate Band 6 and above	L	95%	Avail M3	Avail M3	56.80%	72.90%	80.30%	87.30%	89.50%	91.60%	92.90%	94.50%	97.33%	97.50%	56.80%	87.30%	92.90%	97.50%		4	
	Appraisal Rate Band 5 and below	L	95%	Avail M6	Avail M6				66.30%	75.80%	80.30%	83.60%	89.20%	96.59%	96.90%	Avail M6	66.30%	83.60%	96.90%		4	
Mandatory Training	Aggression Management	L	80%	73.70%	73.65%	75.83%	77.04%	78.89%	78.85%	80.38%	80.78%	83.12%	82.53%	83.18%	83.20%	75.83%	78.85%	83.12%	83.20%		1	
	Equality, Diversity & Inclusion	L	80%	82.30%	84.55%	84.87%	85.76%	87.17%	88.28%	88.81%	89.37%	90.31%	90.58%	91.39%	92.21%	84.87%	88.28%	90.31%	92.21%		4	
	Fire Safety	L	80%	86.50%	86.24%	86.31%	86.55%	86.44%	85.33%	84.60%	84.83%	85.56%	83.78%	86.66%	86.69%	86.31%	85.33%	85.56%	86.69%		4	
	Food Safety	L	80%	65.20%	66.89%	69.00%	70.67%	71.80%	73.06%	74.30%	74.10%	75.79%	75.36%	76.99%	78.41%	69.00%	73.06%	75.79%	78.41%		1	
	Infection, Prevention & Control & Hand Hygiene	L	80%	80.60%	82.09%	82.82%	83.69%	85.25%	85.55%	85.58%	84.86%	85.84%	86.52%	88.24%	87.60%	82.82%	85.55%	85.84%	87.60%		4	
	Information Governance	L	95%	91.90%	92.55%	92.67%	92.78%	92.73%	91.96%	91.58%	90.58%	89.08%	82.42%	95.12%	95.98%	92.67%	91.96%	89.08%	95.98%		4	
	Safeguarding Adults	L	80%	82.80%	82.60%	84.14%	84.95%	86.16%	86.94%	87.74%	87.34%	88.34%	88.65%	89.40%	90.19%	84.14%	86.94%	88.34%	90.19%		4	
	Safeguarding Children	L	80%	84.70%	85.22%	86.00%	86.39%	87.12%	87.93%	86.12%	85.54%	87.68%	88.22%	89.21%	89.95%	86.00%	87.93%	87.68%	89.95%		4	
	Moving & Handling	L	80%	71.60%	73.66%	75.31%	77.40%	79.32%	80.37%	82.11%	83.03%	83.83%	84.67%	85.89%	85.64%	75.31%	80.37%	83.83%	85.64%		1	
	Safer Staffing	Safer Staffing - Fill Rate (Nurses)	L	90%	91.80%	94.20%	96.30%	94.40%	91.10%	92.80%	95.90%	97.60%	93.90%	93.70%	95.90%	94.10%	96.30%	92.80%	93.90%	94.10%		4
Safer Staffing - Fill Rate (HCA's)		L	90%	117.60%	118.60%	115.40%	112.90%	112.90%	111.90%	116.10%	113.60%	114.30%	116.00%	116.10%	117.40%	115.40%	111.90%	114.30%	117.40%		4	

KEY		Impact and Delivery
4	Forecast met, no plan required/plan in place likely to deliver	• Performance for Quality indicators (CQUINS) is monitored by BDU's on a monthly basis. The Quarter 4 performance is currently being collated. The risk assessment on achievement of all indicators for 2015/16 is predicting an overall potential shortfall in income of £1.273M, which equates to 73% achievement and the overall rating for the year end position remains at Amber/Green. • Under performance issues related to CQUINS to date are linked to MH Clustering in all BDU's, Care Planning in Calderdale, Kirklees and Wakefield and High Performing Teams in Bamsley - detailed action plans have been drawn to improve performance however, some underperformance is forecast to continue to end of Q4.
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	Operational Effectiveness
CQC	Care Quality Commission	• Issues in performance associated with waiting times for IAPT continue in March 16 and this can be linked in part to psychological wellbeing practitioner vacancies within IAPT teams. Mitigating actions have been put in place, however, the indicator reports against clients that have completed treatment and this is therefore taking time to be evidenced in the performance. There is an underperformance related to the number of new cases of psychosis at end of March 16. This indicator is being removed from the Monitor Risk Assessment Framework in 16/17 and replaced with the Early Intervention access indicator where the focus will be on timely access to services.
M	Monitor	
C	Contract	Workforce
C (FP)	Contract (Financial Penalty)	• Sickness continues to remain above trajectory at end of March 16 and has been static for the last four months. Work continues to focus on reducing sickness related absence within the Trust with specific target being placed on long term sickness. • Food Safety training is now the only area not achieving threshold but has shown an incremental increase month on month since April 15.
L	Local (Internal Target)	
ER	Expected Range	
N/A	Not Applicable	

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 12 Performance	Annual Forecas	Trend from last month	Last 3 Months - Most recent		
Trust Targets					11	10	9
1	Monitor Risk Rating	●	●	↑	●	●	●
2	REVISED £0.10m Surplus on Income & Expenditure	●	●	↑	●	●	●
3	Cash Position	●	●	↑	●	●	●
4	Capital Expenditure	●	●	↔	●	●	●
5	Delivery of CIP	●	●	↔	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

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

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The year end Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible).
2. The year end position is a surplus of £207k which is £107k better than planned. This has been possible through the use of Trust reserves to offset in year pressures arising from healthcare contract income and non pay expenditure within the BDU's.
3. At March 2016 the cash position is £27.11m which is £2.84m ahead of plan.
4. Capital spend to March 2016 is £11.29m which is £0.71m (6%) behind the original Trust capital plan. The main variance relates to IM & T expenditure where schemes have been delivered at a cost less than planned.
5. At March 2016 the Cost Improvement Programme is £1350k behind plan. (14%). In year delivery has also included £2454k of non recurrent schemes.
6. As at March 2016 91% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be a small improvement from previous months.

Contracting

Trust Summary by BDU - Current Contract Performance - Position at month 11

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

QUIN Performance Q4 Forecast based on

Quarter	Quarter 3 £000s	Achieved	Variance	M11 Performance	Variance
Barnsley	£426.6	£378.6	-£48.0	£489.8	-£92.8
Wakefield	£136.1	£70.7	-£65.4	£115.8	-£177.2
Kirklees	£150.3	£76.6	-£73.7	£127.3	-£194.2
Calderdale	£67.4	£34.4	-£33.1	£57.1	-£87.2
Specialised	£75.4	£75.4	£0.0	£56.5	-£18.9
Forensics	£22.5	£22.5	£0.0	£397.4	£0.0
Trust Total	£878.4	£658.2	-£220.1	£1,244.0	-£570.3

QUIN Performance Year-end Forecast

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

Key Contract Issues - Specialist

CAMHS - RiO Issues - Trust wide data potentially 20% under what should be. Main area for CAMHS is uncompleted appointments

C&K: Still awaiting DoV from Commissioners. 2016/17 new contract being issued for 1yr period.

Both C & K services will go out to tender for new contract in 17/18.

Barnsley: Task & Finish Group dissolved. Future contracting issues to be picked up within main BCCG meetings

Wakefield: WCCG focussing on service delivery and make up. Potential in year review.

Learning Disability

W - constraints on the number of patients able to be admitted against contract plan due to intake of complex client

C - SWYPFT team delivering on timescales. Positive feedback and service being recognised as good practice

Key Contract Issues - Barnsley

Wakefield MDC - SWYPFT is agreeing to an extension to 30/09/16 and a 3% reduction in value

Rotherham & Doncaster MBCs PH - SWYPFT is agreeing a contract reduction against the Drugs which is a pass through

Substance Misuse Services - SWYPFT is agreeing the new model & transition costs with PF service. SWYPFT has done so with a model costing £558k, current contract value is £1,079k

QIPP Targets & Delivery for 2015/16

CCG	Target £000s	Planned £000s	Remainder £000s	RAG
Wakefield*	£1,790.0	£1,843.3	£53.3	***
Kirklees**	£1,000.0	£595.6	-£404.4	
Calderdale	£0.0	£0.0	£0.0	
TOTAL £000s	£2,790.0	£2,438.8	-£351.2	

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme

*** W RAG remains at R as risks identified ~ see summary below

Proposals under the QIPP scheme -

W:- £1.79m in total. OOA Bed Mgt - above plan: OPS Reconfiguration (Saville Park) - on target: MH contract reduction - delivered: OAPs for LD & CHC (CCG held budgets)- high risk: Castle Lodge (CCG budget - prevention client OOA) ~ CCG contesting this £47k : Repricing LD beds - ongoing:

Risk within plan as includes £41k for use of Barnsley PICU bed & SWYPFT funded £338k

from contract growth for ADHD sustainable case & backlog clearance ~tbc by CCG

C:- 15/16 Schemes to be identified by end of Q1. Potential Productivity Schemes identified, not finalised/agreed.

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. Below target

KPIs and Penalties

Commissioner	Penalty £000s	Comment
Barnsley CCG	£2.2	MSK as at Mth 11

Key Contract Issues - Kirklees

Psychology: 18 week pathway holding although there has been an increase in referrals. Waiting lists beginning to reduce.

IAPT: Remaining below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment).

Police Liaison: £150k funding for GH for 2.2 wte staff. 12hr day service with SWYPFT staff being co-located with the Police. Rapid Response pathway to operate utilising IHBT capacity to provide overall cover.

Key Contract Issues - Calderdale

Police Liaison: £150k funding for Calderdale for 2.2 wte staff. 12hr day service with SWYPFT staff being co-located with the Police. Rapid Response pathway to operate utilising IHBT capacity to provide overall cover.

R&R: CCCG clear about intentions re redesign of pathway. Joint pathway with health & social care. Move from bed based approach and moving to community rehab model.

IAPT (AQP): DoV signed by SWYPFT. Awarded tender for future provision.

ED: Agreement for a B6 Care Co-ordinator to coordinate existing ED cases Feb 16-31st Mar 17

Key Contract Issues - Forensics

National procurement identified for 2015/16/17 for Medium & Low Secure MH Services with CAMHS likely to be in first lot.

Key Contract Issues - Wakefield

Key Contract Issues - Health & Wellbeing

Negotiations are ongoing with Wakefield MDC & Rotherham & Doncaster MBS with regard to changes in their contracts for 2016/17

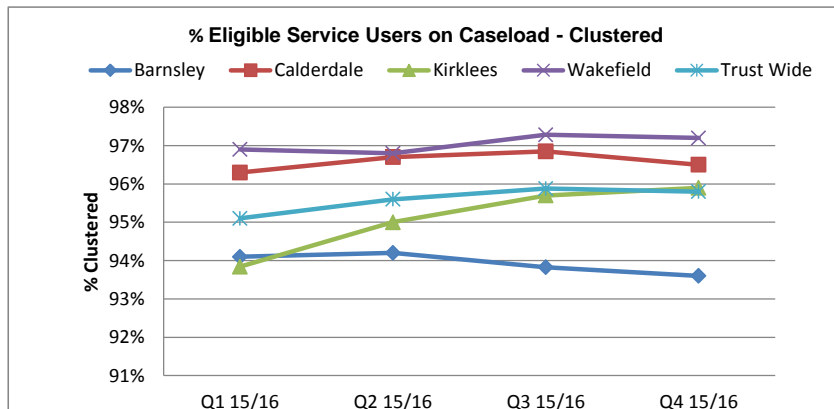
Mental Health

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, this assessment must be regularly reviewed in line with the timing and protocols. It is the intention that clusters will form the basis of the contracting arrangements between commissioners and providers, the commencement of this is not yet clear.

The Trust have been at the forefront of developments of the mental health clustering process and have had strong links into the national project. The clustering is now embedded into operational practice and the below are key priorities within the Trust related to development of mental health currencies.

Person First and in the Centre - access to timely assessment

At the end March 16, the Trust have achieved 95.8% of service users clustered against a national target of 95%. There are some under performance issues within individual BDU's and each BDU has a trajectory of improvement:



Trajectory of improvement to be set for 16/17 based on 15/16 Q4.

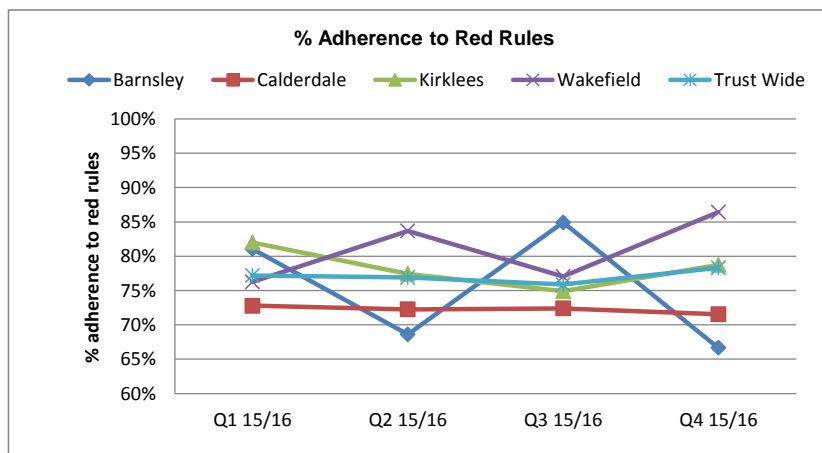
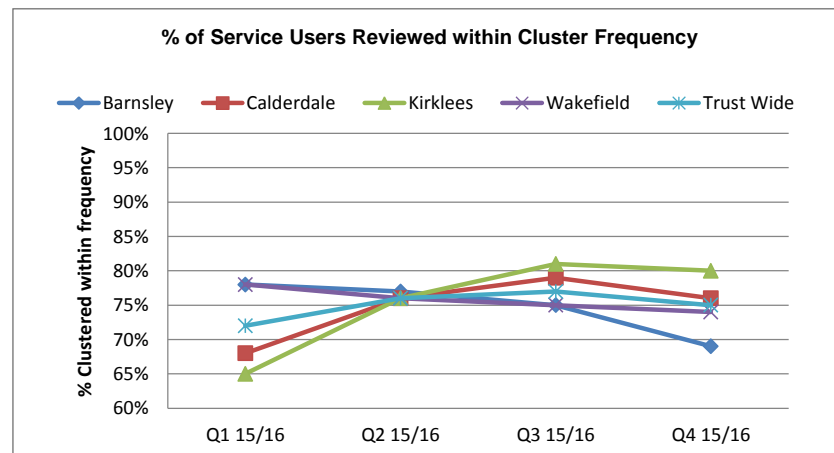
Barnsley BDU - Engaged with Transition and Development Manager- action plan to be developed over the next month as there has been a definite decline in performance overall.

Calderdale BDU - Refresher sessions taking place; Shared Governance group being developed for sustainability.

Kirklees BDU - OPS have process in place to review all medical caseloads and data cleansing-meet monthly; members of OPS staff assisting with the review of the people never clustered, 12 month out of review date; Training sessions being set up and identified staff for shared governance group ; Support identified in WAA; Support and refresher training to be undertaken with the Dual diagnosis team.

Wakefield BDU - Support identified for WAA CMHT; Shared Governance group commencing April; Caseload Reviewer in post for one year, who is also carrying out training; Concentrated efforts supporting and data cleansing OPS Medical staff; Meeting with TRIOs and attending service line meetings ; Caseload reviewer carrying out training with IHBTT staff, and all inpatient staff

Recovery with the use of the care pathway to facilitate recovery - promoting relationships



This KPI measures assurance that the cluster is accurate, complete and of high quality

Currency Development

The care package (Interventions) are our core business and the care we deliver supports the individual person receive the right care through shared decision- making, self management, person centred 'safety planning, consistently, through competence, listening and communication to support recovery

KPI's that are associated with this are:

* % with a MHCT on CPA/standard care

% with MHCT at discharge

This has been identified as an area for training as the Trusts new CPA policy is now in place. Reporting and monitoring for this will commence during quarter 1.

Training and refresher training across the whole Trust will commence once the national MHCT booklet V5 is published.

Outcome measures and reporting of these are being developed across the Trust, these include:

Clinician Rated Outcome Measures

Patient Rated Outcome Measures

Patient Related Experience Measures

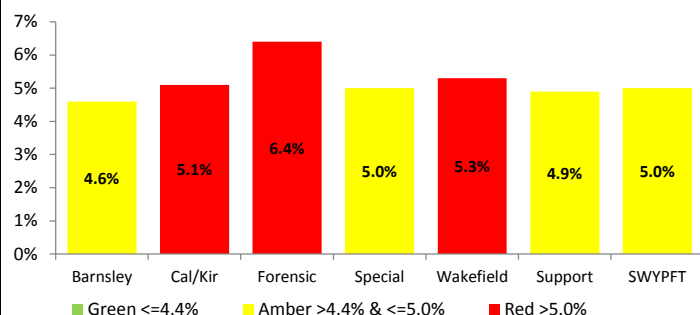
Other developments to be considered and supported within the Trust relate to clustering for Learning Disabilities, Children & Adolescent Mental Health Services, Forensic, Improving Access to Psychological Therapies (IAPT).

Community Services

The NHS Pricing Authority and case mix team at HSCIC are working in partnership to develop a national currency for community services. The partnership have hosted a number of national events which the Trust has been engaged in. The Trust are keen to be involved in this development and have expressed an interest in involvement of the Community Steering group who will provide governance for community dataset development which will feed into the currencies project. Nationally, organisations have been sharing local work on community currencies. These ideas and local innovations across England are being incorporated into the project. The project is keen for the currency design to resonate with the way services are developing.

Human Resources Performance Dashboard - March 2016

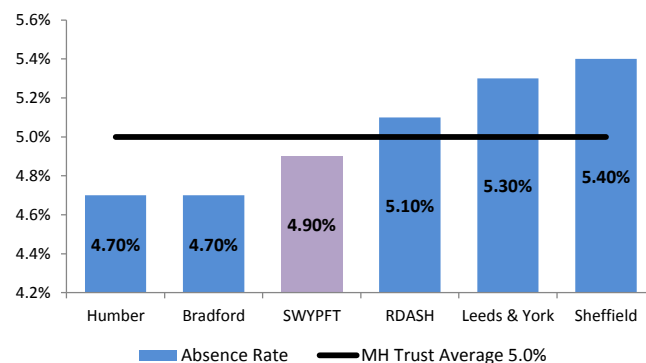
Sickness Absence



Current Absence Position - February 2016

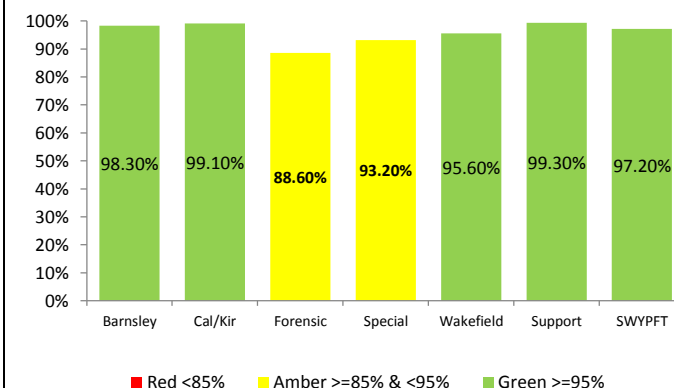
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.5%	5.6%	5.7%	6.5%	4.1%	3.7%	5.2%
Trend	↓	↑	↓	↑	↓	↑	↓

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



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

Appraisals - All Staff



The above chart shows the YTD appraisal rates for all Trust staff to the end of March 2016.

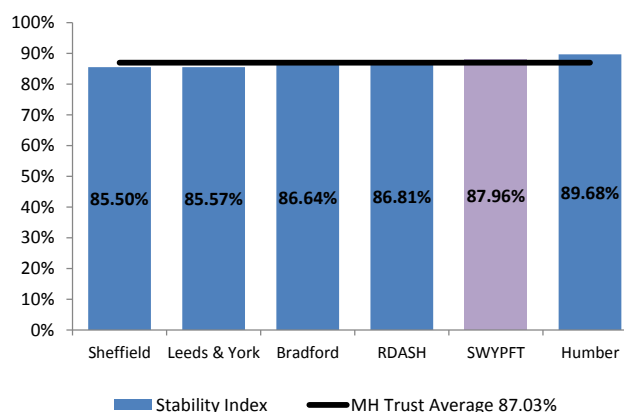
The Trust's target for appraisals is 95% or above.

All areas have shown improvement each month since the inclusion of Bands 1 to 5 in the figures in September 2015.

Turnover and Stability Rate Benchmark

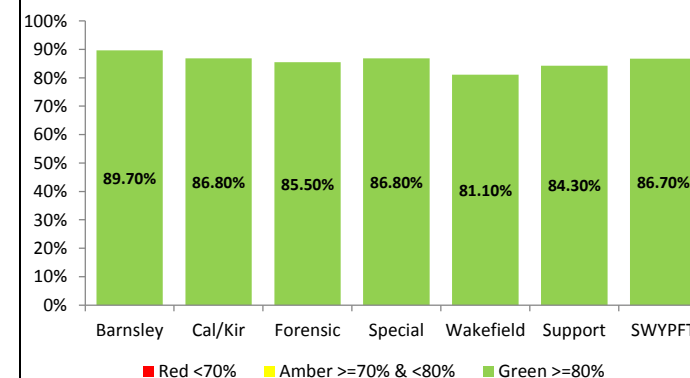


This chart shows the YTD turnover levels up to the end of March 2016.



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

Fire Lecture Attendance



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

Workforce - Performance Wall

Trust Performance Wall							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.90%	4.90%	5.00%	5.00%	5.00%	5.00%
Sickness (Monthly)	<=4.4%	4.90%	5.30%	5.40%	5.00%	5.50%	5.20%
Appraisals (Band 6 and above)	>=95%	89.50%	91.60%	92.80%	94.50%	97.30%	97.50%
Appraisals (Band 5 and below)	>=95%	75.80%	80.10%	83.50%	89.20%	96.60%	96.90%
Aggression Management	>=80%	80.40%	80.80%	83.10%	82.50%	83.20%	83.20%
Equality and Diversity	>=80%	88.80%	89.40%	90.30%	90.60%	91.40%	92.20%
Fire Safety	>=80%	84.60%	84.80%	85.60%	83.80%	86.70%	86.70%
Food Safety	>=80%	74.30%	74.10%	75.80%	75.40%	77.00%	78.40%
Infection Control and Hand Hygiene	>=80%	85.60%	84.90%	85.80%	86.50%	88.20%	87.60%
Information Governance	>=95%	91.60%	90.60%	89.10%	82.40%	95.10%	96.00%
Moving and Handling	>=80%	82.10%	83.00%	83.80%	84.60%	85.90%	85.60%
Safeguarding Adults	>=80%	87.70%	87.30%	88.30%	88.70%	89.40%	90.20%
Safeguarding Children	>=80%	86.10%	85.50%	87.70%	88.20%	89.20%	89.90%
Bank Cost		£478k	£428k	£414k	£426k	£419k	£548k
Agency Cost		£772k	£770k	£606k	£527k	£774k	£1449k
Overtime Cost		£30k	£37k	£22k	£31k	£30k	£33k
Additional Hours Cost		£74k	£87k	£89k	£64k	£70k	£103k
Sickness Cost (Monthly)		£475k	£546k	£533k	£515k	£576k	£483k
Vacancies (Non-Medical) (WTE)		324.2	306.46	316.89	353.49	380.25	400.13
Business Miles		333k	347k	323k	327k	323k	257k

Calderdale and Kirklees District							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.80%	5.00%	5.10%	5.00%	5.10%	5.10%
Sickness (Monthly)	<=4.4%	5.10%	6.60%	5.60%	4.80%	5.90%	5.60%
Appraisals (Band 6 and above)	>=95%	98.80%	99.70%	99.10%	99.70%	100.00%	100.00%
Appraisals (Band 5 and below)	>=95%	85.00%	88.80%	91.70%	92.50%	98.40%	98.40%
Aggression Management	>=80%	83.20%	82.80%	86.10%	87.30%	87.20%	85.40%
Equality and Diversity	>=80%	90.60%	91.60%	92.00%	93.20%	92.40%	92.80%
Fire Safety	>=80%	83.00%	83.20%	85.40%	83.00%	86.10%	86.80%
Food Safety	>=80%	69.50%	70.20%	72.00%	74.50%	74.10%	72.10%
Infection Control and Hand Hygiene	>=80%	88.60%	90.00%	90.40%	91.10%	90.70%	88.60%
Information Governance	>=95%	90.40%	89.80%	87.50%	83.30%	96.30%	96.70%
Moving and Handling	>=80%	81.30%	82.70%	83.40%	84.30%	85.20%	84.80%
Safeguarding Adults	>=80%	86.60%	86.80%	88.20%	88.90%	88.50%	89.70%
Safeguarding Children	>=80%	86.20%	86.50%	89.40%	91.00%	90.40%	90.60%
Bank Cost		£117k	£124k	£114k	£123k	£147k	£161k
Agency Cost		£199k	£173k	£117k	£124k	£182k	£246k
Overtime Cost		£1k	£2k	£0k	£3k	£0k	£3k
Additional Hours Cost		£2k	£3k	£3k	£2k	£5k	£5k
Sickness Cost (Monthly)		£101k	£142k	£116k	£97k	£131k	£107k
Vacancies (Non-Medical) (WTE)		71.14	75.66	72.44	69.5	64.92	64.88
Business Miles		65k	73k	61k	63k	62k	56k

Barnsley District							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.10%	4.20%	4.30%	4.40%	4.60%	4.60%
Sickness (Monthly)	<=4.4%	4.20%	4.50%	5.10%	5.20%	5.90%	5.50%
Appraisals (Band 6 and above)	>=95%	92.10%	94.40%	95.60%	97.20%	98.20%	98.60%
Appraisals (Band 5 and below)	>=95%	83.30%	87.50%	89.80%	92.10%	97.20%	98.20%
Aggression Management	>=80%	83.50%	82.90%	84.10%	80.80%	82.60%	87.00%
Equality and Diversity	>=80%	90.70%	91.30%	92.60%	93.00%	93.60%	94.70%
Fire Safety	>=80%	84.70%	85.80%	86.20%	85.80%	89.50%	89.70%
Food Safety	>=80%	80.10%	75.70%	74.90%	72.70%	74.20%	77.10%
Infection Control and Hand Hygiene	>=80%	86.40%	87.00%	88.10%	87.80%	90.50%	91.00%
Information Governance	>=95%	92.10%	90.90%	90.50%	86.40%	96.20%	97.40%
Moving and Handling	>=80%	84.50%	85.10%	86.10%	86.40%	88.10%	87.90%
Safeguarding Adults	>=80%	90.00%	89.20%	89.80%	90.10%	91.00%	92.90%
Safeguarding Children	>=80%	87.90%	87.40%	89.00%	89.40%	90.40%	91.70%
Bank Cost		£85k	£75k	£65k	£61k	£61k	£50k
Agency Cost		£119k	£200k	£130k	£170k	£168k	£289k
Overtime Cost		£10k	£17k	£8k	£17k	£16k	£10k
Additional Hours Cost		£35k	£40k	£36k	£33k	£33k	£60k
Sickness Cost (Monthly)		£138k	£155k	£175k	£199k	£230k	£190k
Vacancies (Non-Medical) (WTE)		92.75	85.33	87.34	108.19	124.09	130.8
Business Miles		144k	148k	126k	132k	135k	105k

Forensic Services							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	7.20%	7.00%	6.80%	6.60%	6.50%	6.40%
Sickness (Monthly)	<=4.4%	6.80%	5.80%	5.70%	5.00%	5.30%	5.70%
Appraisals (Band 6 and above)	>=95%	70.00%	74.70%	84.70%	84.10%	86.60%	87.00%
Appraisals (Band 5 and below)	>=95%	66.20%	71.50%	77.60%	83.90%	89.20%	89.10%
Aggression Management	>=80%	78.20%	80.70%	81.70%	80.60%	80.20%	79.70%
Equality and Diversity	>=80%	90.40%	92.40%	92.80%	93.00%	92.90%	93.90%
Fire Safety	>=80%	87.30%	88.60%	89.00%	83.10%	86.40%	85.40%
Food Safety	>=80%	70.60%	73.50%	79.70%	79.60%	82.70%	86.00%
Infection Control and Hand Hygiene	>=80%	85.30%	84.40%	85.40%	87.00%	88.00%	88.40%
Information Governance	>=95%	91.70%	91.90%	90.80%	80.60%	93.00%	94.30%
Moving and Handling	>=80%	85.80%	87.60%	87.90%	88.80%	89.20%	89.20%
Safeguarding Adults	>=80%	88.50%	89.90%	91.50%	91.90%	92.10%	92.10%
Safeguarding Children	>=80%	85.30%	85.90%	87.70%	85.20%	86.10%	87.30%
Bank Cost		£114k	£97k	£86k	£108k	£77k	£142k
Agency Cost		£122k	£68k	£68k	£92k	£143k	£320k
Overtime Cost		£0k	£2k	£0k	£-1k	£0k	£0k
Additional Hours Cost		£0k	£0k	£0k	£0k	£1k	£1k
Sickness Cost (Monthly)		£58k	£56k	£50k	£40k	£44k	£41k
Vacancies (Non-Medical) (WTE)		24.94	24.54	37.11	45.11	49.62	49.57
Business Miles		9k	9k	12k	7k	4k	6k

Specialist Services							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	5.10%	5.00%	4.80%	4.80%	4.80%	5.00%
Sickness (Monthly)	<=4.4%	4.70%	4.60%	4.80%	4.40%	4.60%	6.50%
Appraisals (Band 6 and above)	>=95%	68.70%	73.80%	75.10%	77.90%	91.80%	92.30%
Appraisals (Band 5 and below)	>=95%	47.50%	53.60%	64.80%	71.30%	94.00%	94.70%
Aggression Management	>=80%	76.40%	77.10%	79.80%	81.20%	81.60%	80.00%
Equality and Diversity	>=80%	89.90%	90.00%	90.50%	90.10%	91.30%	92.40%
Fire Safety	>=80%	83.20%	82.10%	84.60%	85.10%	86.00%	86.80%
Food Safety	>=80%	69.00%	71.20%	73.70%	73.20%	74.50%	74.50%
Infection Control and Hand Hygiene	>=80%	84.00%	84.30%	85.90%	86.30%	87.40%	87.30%
Information Governance	>=95%	90.10%	90.20%	89.50%	85.20%	95.90%	96.40%
Moving and Handling	>=80%	82.50%	83.10%	83.10%	84.80%	85.70%	87.00%
Safeguarding Adults	>=80%	83.20%	82.00%	84.40%	84.80%	86.60%	86.80%
Safeguarding Children	>=80%	84.90%	81.30%	85.60%	87.70%	87.80%	87.30%
Bank Cost		£31k	£28k	£32k	£25k	£21k	£30k
Agency Cost		£228k	£216k	£146k	£59k	£173k	£313k
Overtime Cost		£1k	£1k	£1k	£2k	£2k	£1k
Additional Hours Cost		£5k	£7k	£11k	£4k	£9k	£6k
Sickness Cost (Monthly)		£53k	£55k	£45k	£43k	£44k	£54k
Vacancies (Non-Medical) (WTE)		45.31	44.49	40.71	39.15	49.08	55.33
Business Miles		30k	39k	40k	36k	37k	28k

Wakefield District							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	5.30%	5.40%	5.50%	5.40%	5.30%	5.30%
Sickness (Monthly)	<=4.4%	5.60%	5.90%	5.80%	4.80%	5.00%	4.10%
Appraisals (Band 6 and above)	>=95%	88.10%	90.20%	91.80%	95.10%	97.90%	97.90%
Appraisals (Band 5 and below)	>=95%	68.40%	76.70%	81.30%	87.00%	93.90%	93.90%
Aggression Management	>=80%	82.90%	82.80%	84.20%	82.10%	83.80%	85.20%
Equality and Diversity	>=80%	92.20%	92.20%	92.60%	91.50%	92.70%	93.50%
Fire Safety	>=80%	86.10%	84.70%	85.20%	82.50%	82.90%	81.10%
Food Safety	>=80%	68.60%	69.70%	69.50%	68.80%	70.40%	72.30%
Infection Control and Hand Hygiene	>=80%	83.80%	81.80%	82.00%	85.30%	86.70%	84.10%
Information Governance	>=95%	92.60%	91.50%	89.00%	84.40%	97.00%	97.90%
Moving and Handling	>=80%	74.00%	75.70%	77.60%	78.30%	79.00%	78.60%
Safeguarding Adults	>=80%	89.70%	88.90%	89.00%	88.20%	89.70%	88.80%
Safeguarding Children	>=80%	85.60%	85.30%	86.30%	86.40%	87.70%	87.20%
Bank Cost		£71k	£90k	£78k	£72k	£71k	£108k
Agency Cost		£34k	£73k	£71k	£49k	£66k	£145k
Overtime Cost		£14k	£14k	£12k	£10k	£12k	£15k
Additional Hours Cost		£9k	£13k	£12k	£7k	£9k	£8k
Sickness Cost (Monthly)		£63k	£70k	£64k	£55k	£56k	£44k
Vacancies (Non-Medical) (WTE)		36.58	34.71	40.49	45.96	48.79	51.83
Business Miles		43k	44k	37k	44k	43k	31k

Support Services							
Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.70%	4.80%	5.00%	5.00%	5.00%	4.90%
Sickness (Monthly)	<=4.4%	4.80%	5.40%	6.00%	5.40%	4.90%	3.70%
Appraisals (Band 6 and above)	>=95%	95.50%	96.50%	96.50%	98.50%	99.00%	99.00%
Appraisals (Band 5 and below)	>=95%	71.10%	72.70%	74.80%	89.70%	99.60%	99.40%
Aggression Management	>=80%	72.40%	74.30%	78.60%	78.50%	78.90%	76.80%
Equality and Diversity	>=80%	78.70%	78.90%	80.40%	80.90%	84.10%	84.40%
Fire Safety	>=80%	84.60%	84.30%	83.50%	80.90%	84.20%	84.30%
Food Safety	>=80%	90.10%	89.20%	89.90%	87.30%	91.00%	90.90%
Infection Control and Hand Hygiene	>=80%	82.30%	76.80%	78.30%	79.20%	82.00%	81.20%
Information Governance	>=95%	91.70%	89.60%	86.60%	71.30%	90.90%	91.50%
Moving and Handling	>=80%	81.10%	81.50%	81.90%	82.70%	84.80%	83.90%
Safeguarding Adults	>=80%	84.90%	84.50%	85.40%	85.90%	86.90%	86.90%
Safeguarding Children	>=80%	83.70%	82.80%	84.80%	85.50%	88.60%	90.00%
Bank Cost		£60k	£14k	£39k	£38k	£42k	£57k
Agency Cost		£71k	£40k	£74k	£33k	£42k	£135k
Overtime Cost		£4k	£0k	£0k		£0k	£3k
Additional Hours Cost		£22k	£19k	£20k	£17k	£13k	£17k
Sickness Cost (Monthly)		£61k	£68k	£84k	£80k	£72k	£47k
Vacancies (Non-Medical) (WTE)		51.48	36.73	37.2	43.98	41.82	45.57
Business Miles		42k	35k	48k	45k	42k	32k

Publication Summary

NHS England

Sustainability and transformation plan footprints

This document outlines the 44 footprint areas that will bring local health and care leaders, organisations and communities together to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS five year forward view.

[Click here for briefing](#)

Monitor

2016/17 national tariff payment system

This guidance contains a set of prices and rules to help providers of NHS care and commissioners provide best value to their patients. This year's national tariff aims to give providers of NHS services the space to restore financial balance and support providers and commissioners to make ambitious longer term plans for their local health economies.

[Click here for guidance](#)

Care Quality Commission (CQC)

Fees scheme 2016/17

This document outlines the changes to revised fees that providers will have to pay to cover the chargeable costs of CQC regulation for 2016/17. These new fees will take effect from 1 April 2016.

[Click here for provider guidance](#)

NHS England

Our 2016/17 business plan

This business plan builds on three guiding principles to shape the work of NHS England for the year ahead: constancy of purpose and priorities; coherent national support for locally-led improvement; and solving today's issues by accelerating tomorrow's solutions.

[Click here for business plan](#)

Publication Summary cont....

Department of Health

NHS outcomes framework 2016 to 2017 at-a-glance

The NHS outcomes framework will remain unchanged for 2016 to 2017. This document lists the indicators that will be used to hold NHS England to account for improvements in health outcomes.

[Click here for outcomes framework](#)

Department of Health

Multi-agency statutory guidance on female genital mutilation (FGM)

These multi-agency guidelines on FGM are aimed at those with statutory duties to safeguard children and vulnerable adults. It supersedes the previous guidance issued in 2014, 'Female genital mutilation: guidelines to protect women and children'.

[Click here for guidance](#)

NHS England

CCG improvement and assessment framework 2016/17

This new assessment framework for CCGs will include ratings published online to show patients how their local health service is performing in six important areas. From June, an initial assessment of CCG performance will be available online that will cover six crucial areas including cancer, dementia, diabetes, mental health, learning disabilities and maternity care. Each will be based on metrics in the framework that will be verified by independent panels chaired by experts in each field. This will be followed by an annual assessment in June 2017 which will incorporate additional

[Click here for framework](#)

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

Combined performance summary, January 2016

Hospital activity data, January 2016

Direct access audiology waiting times, January 2016

Mixed sex accommodation breaches, February 2016

Diagnostic imaging dataset, March 2016

Winter health watch summary, 17 March 2016

Winter health watch summary: 24 March 2016

NHS workforce statistics, December 2015, provisional statistics

NHS sickness absence rates, November 2015, provisional statistics

Hospital activity data, February 2016

Glossary

ADHD	Attention deficit hyperactivity disorder	LD	Learning Disability
AQP	Any Qualified Provider	Mgt	Management
ASD	Autism spectrum disorder	MAV	Management of Aggression and Violence
AWA	Adults of Working Age	MBC	Metropolitan Borough Council
AWOL	Absent Without Leave	MH	Mental Health
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield	MHCT	Mental Health Clustering Tool
BDU	Business Delivery Unit	MRSA	Methicillin-resistant Staphylococcus aureus
C&K	Calderdale & Kirklees	MSK	Musculoskeletal
C. Diff	Clostridium difficile	MT	Mandatory Training
CAMHS	Child and Adolescent Mental Health Services	NCI	National Confidential Inquiries
CAPA	Choice and Partnership Approach	NHS TDA	National Health Service Trust Development Authority
CCG	Clinical Commissioning Group	NHSE	National Health Service England
CGCSC	Clinical Governance Clinical Safety Committee	NICE	National Institute for Clinical Excellence
CIP	Cost Improvement Programme	NK	North Kirklees
CPA	Care Programme Approach	OOA	Out of Area
CPPP	Care Packages and Pathways Project	OPS	Older People's Services
CQC	Care Quality Commission	PbR	Payment by Results
CQUIN	Commissioning for Quality and Innovation	PCT	Primary Care Trust
CROM	Clinician Rated Outcome Measure	PICU	Psychiatric Intensive Care Unit
CRS	Crisis Resolution Service	PREM	Patient Reported Experience Measures
CTLD	Community Team Learning Disability	PROM	Patient Reported Outcome Measures
DoV	Deed of Variation	PSA	Public Service Agreement
DQ	Data Quality	PTS	Post Traumatic Stress
DTOC	Delayed Transfers of Care	QIA	Quality Impact Assessment
EIA	Equality Impact Assessment	QIPP	Quality, Innovation, Productivity and Prevention
EIP/EIS	Early Intervention in Psychosis Service	QTD	Quarter to Date
EMT	Executive Management Team	RAG	Red, Amber, Green
FOI	Freedom of Information	RiO	Trusts Mental Health Clinical Information System
FT	Foundation Trust	Sis	Serious Incidents
HONOS	Health of the Nation Outcome Scales	S BDU	Specialist Services Business Delivery Unit
HSCIC	Health and Social Care Information Centre	SK	South Kirklees
HV	Health Visiting	SMU	Substance Misuse Unit
IAPT	Improving Access to Psychological Therapies	SU	Service Users
IG	Information Governance	SWYFT	South West Yorkshire Foundation Trust
IHBT	Intensive Home Based Treatment	SYBAT	South Yorkshire and Bassetlaw local area team
IM&T	Information Management & Technology	TBD	To Be Decided/Determined
Inf Prevent	Infection Prevention	WTE	Whole Time Equivalent
IWMS	Integrated Weight Management Service	Y&H	Yorkshire & Humber
KPIs	Key Performance Indicators	YTD	Year to Date



With all of us in mind

**Members' Council
6 May 2016**

Agenda item:	11.1
Report Title:	Elections to the Members' Council
Report By:	Dawn Stephenson
Job Title:	Director of Corporate Development
Action:	To receive

EXECUTIVE SUMMARY

Purpose and format

The purpose of this paper is to update the Members' Council on the outcome of the election process for 2016.

Recommendation

The Members' Council is asked to RECEIVE the update.

Background

When the Trust was working towards Foundation Trust status, a decision was made by Trust Board to stagger the terms of office for the governors elected in the first elections to the Members' Council to ensure that not all left at the same time. The Trust, therefore, holds elections every year during the spring for terms of office starting on 1 May each year.

Election process

The Nominations process opened on 17 February 2016 and closed on 17 March 2016. Nominations were received as follows.

Barnsley (one seat) – one nomination received
Calderdale (two seats) – five nominations received
Kirklees (three seats) – five nominations received
Wakefield (two seats) – two nominations received
Rest of South and West Yorkshire (one seat) – no nominations received

Staff

- nursing support – one nomination received (*NB this was subject to a bi-election, nominations for which closed on 25 April 2016*)
- social care staff working in integrated teams – no nominations received

Outcome

As a result of the nominations process, the following were elected unopposed from 1 May 2016 for a period of three years.

Barnsley
Shaun Adam
Nursing support
Gemma Wilson

Wakefield
Bob Clayden
Peter Walker (re-elected for third term)

An election is currently being held for the public seats in Calderdale and Kirklees, which ends on 28 April 2016. The outcome of the election will be known on 29 April 2016.

Vacancies remain as follows:

- Rest of South and West Yorkshire (public) – one seat;
- Staff in integrated teams (staff) – one seat.



With all of us in mind

**Members' Council
6 May 2016**

Agenda item:	11.3
Report Title:	Review of Audit Committee terms of reference
Report By:	Dawn Stephenson
Job Title:	Director of Corporate Development
Action:	To agree

Introduction

In January 2015, at the request of the Audit 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 were 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 of reference with recognised best practice (Healthcare Financial Management Association Audit Committee Handbook and NHS Providers Foundations of Good Governance) and the existing terms of reference were found to be fit for purpose against both. It was agreed to consider the points raised during the coming year following wider discussion and consultation with the Chair of the Trust. The changes were subsequently approved by Trust Board.

Action to take forward

One of the actions suggested by Deloitte and agreed with the Chair to take forward was consultation with the Members' Council on the Audit Committee's terms of reference. This reflects provision C.3.2b in Monitor's Code of Governance for foundation trusts that "The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly".

The Committee's terms of reference are reviewed on an annual basis as part of the Committee's annual report to Trust Board, which is presented in April each year, and presented here for the Members' Council to consider.

It should be noted that the terms of reference meet best practice guidance and were considered fit for purpose as part of the independent well-led review of the Trust's governance arrangements last year.

Recommendation

The Members' Council is asked to NOTE and CONSIDER the terms of reference for the Audit Committee.



With all of us in mind

AUDIT COMMITTEE Terms of Reference

Approved by Trust Board 29 March 2016

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board.

Purpose

The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance.

Membership

Taking guidance from Monitor and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

Membership as at 1 April 2016

Chair – Laurence Campbell (Non-Executive Director);

Chris Jones (Non-Executive Director);

Jonathan Jones (Non-Executive Director).

Attendance

The Director of Finance is in attendance (as lead Director) at meetings. The Director of Corporate Development also attends meetings as the duties of the Company Secretary are encompassed in her role. Representatives of internal and external audit are also invited and expected to attend. The Chair of the Trust, the Chief Executive and other Executive Directors attend the Audit Committee by invitation.

Administrative support is provided by the Integrated Governance Manager as Secretary to Trust Board.

Quorum

The quorum will be two Non-Executive Directors (including the Chair of the Committee); however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. There will also be an additional meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Duties

Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board;
- the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework and providing assurance that action plans are in place to address significant control issues;
- the policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the Monitor risk assessment framework;
- the systems for internal control including the risk management strategy, risk management systems and the risk register;
- the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service;
- the work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action;
- ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively;
- such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed; and
- these processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

Internal Audit

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets NHS Internal Audit Standards that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal;
- review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources;
- ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses;

- development and implementation of a policy on the provision of non-audit services by the External Auditor.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Protect Standards for Providers and as required by NHS Protect. In particular:

- consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- receive and review the annual report prepared by the Local Counter Fraud Specialist;
- receive update reports on any investigations that are being undertaken.

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to Monitor, Trust Board and the Members' Council. In particular, the Committee shall focus on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas; and
- significant adjustments arising from the annual audit.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as to be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- examines the circumstances associated with each occasion Standing Orders are waived;
- reviews schedules of losses and compensations on behalf of Trust Board.

Relationship with the Members' Council

To reflect best practice and Monitor's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting.

The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.