South West Yorkshire Partnership NHS
NHS Foundation Trust

**Trust Board (performance and monitoring)**
**Tuesday 28 June 2016 at 10:00**
**Rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR**

# AGENDA

1. **Welcome, introduction and apologies** (verbal item)

2. **Declaration of interests** (attached)

3. **Minutes and matters arising from previous Trust Board meeting held on 28 April 2016** (attached)

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

5. **Care Quality Commission inspection report** (attached)

6. **Performance reports month 2 2016/17**
   - 6.1 Performance report month 2 2016/17 (to follow)
   - 6.2 Finance report month 2 2016/17 (attached)
   - 6.3 Exception reporting and action plans
     - (i) Transformation update (attached)
     - (ii) Incident management annual report (attached)
     - (iii) Customer services annual report (attached)
     - (iv) Safety management and contingency planning annual report (attached)

7. **Governance matters**
   - 7.1 Annual report, accounts and quality accounts (attached)
   - 7.2 Corporate Governance Statement (attached)

**8. Assurance from Trust Board committees** (attached)

8.1 Audit Committee 23 May 2016
8.2 Clinical Governance and Clinical Safety Committee 17 May and 14 June 2016
8.3 Mental Health Act Committee 17 May 2016
8.4 Remuneration and Terms of Service Committee 24 May 2016
8.5 Estates Forum 7 June 2016
8.6 Equality and Inclusion Forum 21 June 2016
8.7 Membership of Committees from 1 July 2016 (attached)

**9. Use of Trust seal** (attached)

**10. Date and time of next meeting**

The next meeting of Trust Board will be held on Tuesday 19 July 2016 in the Boardroom, Kendray, Doncaster Road, Barnsley, S70 3RD.

# Trust Board 28 June 2016
# Agenda item 2

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| **Title:** | **Declaration of interests by the Chair and Directors of the Trust** |
| **Paper prepared by:** | Director of Corporate Development on behalf of the Chair of the Trust |
| **Purpose:** | To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency. |
| **Mission/values:** | The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this. |
| **Any background papers/ previously considered by:** | Annual declaration made by the Chair and Directors of the Trust April 2015 and subsequent declarations made. |
| **Executive summary:** | The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board.<br><br>Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise, received in April 2015, and the requirement for the Chair and Directors to consider and declare any interests at each meeting.<br><br>There are no legal implications; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. There is also a requirement for the Trust to assure itself that members of its Board meeting the fit and proper person requirements.<br><br>Declarations made by new Directors are as follows.<br><u>Chief Executive – Rob Webster</u><br>➢ Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England)<br>➢ Visiting Professor, Leeds Beckett University<br>➢ Honorary Fellow, Queen's Nursing Institute<br>➢ Honorary Fellow, Royal College of General Practitioners<br>➢ National champion on adoption of innovation for accelerated access review<br><u>Director of Finance – Mark Brooks</u> – no interests declared.<br><u>Interim Director of Strategic Planning – James Drury</u> – no interests declared. |

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| | All have also made a declaration that they meet the fit and proper person requirements. |
| **Recommendation:** | **Trust Board is asked to CONSIDER the declaration, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.** |
| **Private session:** | Not applicable |

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Minutes of Trust Board meeting held on 28 April 2016

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| **Present:** | Ian Black | Chair |
| | Laurence Campbell | Non-Executive Director |
| | Rachel Court | Non-Executive Director |
| | Charlotte Dyson | Non-Executive Director |
| | Julie Fox | Deputy Chair |
| | Chris Jones | Non-Executive Director |
| | Alex Farrell | Interim Chief Executive |
| | Adrian Berry | Medical Director |
| | Tim Breedon | Director of Nursing, Clinical Governance and Safety |
| | Jon Cooke | Interim Director of Finance |
| | Alan Davis | Director of Human Resources and Workforce Development |
| **Apologies:** | Jonathan Jones | Non-Executive Director |
| **In attendance:** | Kate Henry | Director, Marketing, Engagement and Commercial Development |
| | Dawn Stephenson | Director of Corporate Development (Company Secretary) |
| | Rob Webster | Chief Executive (designate) |
| | Bernie Cherriman-Sykes | Board Secretary (author) |
| **Guests:** | Bob Mortimer | Publicly elected governor (Kirklees), Members' Council |
| | Michael Smith | Publicly elected governor (Calderdale), Members' Council |



## TB/16/22 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular, Rob Webster (RW), Chief Executive (designate) who will formally join the Trust on 16 May 2016. The apology from Jonathan Jones (JJ) was noted.

IB invited Julie Fox (JF) to update Trust Board on the story of Mr. D, previously an in-patient on Chantry, Fieldhead, Wakefield. JF reported that Mr. D was very impressed with the developments and improvements undertaken. He welcomed the feedback from Trust Board and appreciated that there were a number of issues still for discussion, such as uniforms. He very much felt he had been listened to and would like to join the patient-led assessment of the care environment (PLACE) inspection team. Rachel Court (RC) commented that she would hope that anyone who approaches the Trust with a concern or issue is listened to in the same way. Dawn Stephenson (DS) responded that the Trust offers a direct response to anyone who raises concerns and issues. The Trust will not always be able to resolve an issue in a way an individual would like but it will explain why it is unable to do so.

## TB/16/23 Declaration of interests (agenda item 2)

There were no declarations made over and above those made in March 2016.

## TB/16/24 Minutes of and matters arising from the Trust Board meeting held on 29 March 2016 (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 29 March 2016 as a true and accurate record of the meeting.** There was one matter arising.

TB/16/17 Annual plan and budgets 2016/17

IB confirmed that the Chair, Deputy Chair, interim Chief Executive and interim Director of Finance had approved the final version of the operational plan and the budget (as approved

by Trust Board on 29 March 2016) under delegated authority on 18 April 2016 for submission to NHS Improvement.

## TB/16/25 Assurance from Trust Board committees (agenda item 4)

TB/16/25a Audit Committee 5 April 2016 (agenda item 4.1)

The following were raised.

- There was nothing to indicate that there would not be a Head of Internal Audit Opinion of significant assurance.
- Regarding a recent prosecution for corporate manslaughter, the Committee had been assured that a piece of work had been undertaken by the Trust's Legal Services Team to assess the implications and risk, and this will be reviewed on an ongoing basis. No further action was deemed necessary at this time.
- There will be greater emphasis on the difference Committees make for the annual report in 2016/17. Tim Breedon (TB) commented that evaluation of the work of Committees will be testing and there will need to be serious consideration of how this is done. It may be that a set of proxy indicators to test the difference and impact Committees make could be developed.
- Both the internal audits of medicines management and job planning provided an opinion of 'requires improvement'. For medicines management, a series of recommendations have been made, which will be monitored by the Drugs and Therapeutics TAG led by Adrian Berry (ABe) and the Chief Pharmacist. For job planning, recommendations will be implemented and followed up during 2016 again led by ABe.
- The Committee also received an update on progress with the audit of the Quality Accounts local indicator (care programme approach). TB confirmed there had been a number of issues raised by Deloitte; however, these have been resolved and will be reported through the Members' Council Quality Group and the Clinical Governance and Clinical Safety Committee.
- The Committee also considered the requirements of enhanced auditor reporting and agreed that this was unlikely to add value to the process or aid understanding of the Trust's financial position. The Committee agreed not to propose early adoption of the requirements.

TB/16/25b Clinical Governance and Clinical Safety Committee 18 April 2016 (agenda item 4.2)

The following areas were raised.

- The Committee received a further update on the Trust's approach to suicide prevention and an update on the Trust's participation in local Vanguards.
- In relation to child and adolescent mental health services (CAMHS), issues with data and the establishment of a dashboard remain. The Committee will continue to monitor closely.
- The Committee received a report on a pilot in Barnsley to support service users into employment. The Committee was particularly pleased to see the progress made and would like to see the work replicated in other BDUs. IB asked if the Trust should consider putting the pilot up as an exemplar of best practice. JF responded that the approach was not yet at that stage but it may be possible as work develops in conjunction with partners. Charlotte Dyson (CD) commented that this is an excellent example of an organisation that does things differently. Chris Jones (CJ) asked whether there was any tracking of how long individuals stay in employment and, therefore, show that the Trust's approach is sustainable. The aim should be for the Trust to support people into long-term employment.

TB/16/25c Information Management and Technology Forum 18 April 2016 (agenda item 4.3)
IB reported that a key issue for the Forum was the upgrade to the Trust's clinical information system (RiO) and the continuing difficulties for staff in using the system. The Forum was advised that there will be a 're-launch' of the system. JF commented that this had been raised by the 'shadow board' and that it remains problematic and frustrating for staff. IB confirmed that an independent report has been commissioned by DS, as Company Secretary, and the Trust is considering its position with regard to the supplier.

The following comments were made as part of the discussion.

- JF commented that it is recognised that the Trust is communicating with staff but this needs to continue.
- Jon Cooke (JC) reported that the Trust met with the Managing Director of Servelec the previous day and progress has been made. An underlying issue was identified, which will be tested and a resilient solution found.
- JC also reported that Servelec has indicated that it would wish to be part of the re-launch in partnership with the Trust.
- CD commented that it is important training is in place for staff and Alex Farrell (AF) responded that there is an ongoing programme in place, which is targeted at specific teams.
- CJ asked if there were any patient safety risks as a result and, if so, how these are managed. AF responded that the situation affects staff ability to record clinical information. The Trust is doing as much as it can through advice and support to staff to minimise risk in terms of clinical record keeping as well as reviewing incidents on DATIX in relation to RiO. ABe added that the ongoing issues are not obviously patient safety issues and there is a well-established protocol in place for record keeping when RiO is not available; however, this is a time consuming process.
- It was generally felt that, from discussions with Servelec, it is not fully appreciated how the Trust uses and relies on the system.

## TB/16/26 Chair and Chief Executive's remarks (agenda item 5)

IB began his remarks by referring to the elections for the Members' Council. There will be two elections; one in Calderdale, where five candidates are seeking election to two seats, and Kirklees, where five candidates are seeking election to three seats. This is a democratic process, which means the Trust has no influence over the process and, potentially, loses skills and experience gained over time. The Trust is not able to provide a statement of how much an individual's contribution is appreciated even though annual appraisals are undertaken for all governors.

He went on to comment that this is AF's last meeting. Performance across the Trust can be attributed to her diligence and expertise and, on behalf of Trust Board, he thanked AF and wished her the best for her retirement. In response, AF thanked Trust Board for an interesting and challenging six years. She went on to comment on the following.

- The Trust submitted its operational plan by the required date. The Trust has not accepted the control total of £1.2 million and is forecasting £500,000 surplus. In the follow up call, NHS Improvement did not particularly challenge the Trust's position; however, there was much interest in the Trust's capital plan in terms of reviewing the capital plan and benefits of investment. The Trust is clear as to the benefits of its planned capital investments; however, the capital plan may be subject to review by NHS Improvement. When the Care Quality Commission (CQC) report is received, there will be a further review of the Trust's financial position by Trust Board.
- The Trust is involved in the development of Sustainability and Transformation Plans (STPs) in South and West Yorkshire. Each has overarching workstreams and key

priorities for the region, including mental health. The Urgent and Emergency Care Vanguard in West Yorkshire offers a platform to support the STPs in terms of the acute pathway. STPs are required by 30 June 2016, setting out ambitions to meet outcomes, improve care and quality, and address financial gaps to improve health and wellbeing through partnership working. An update on the submissions will come to the June meeting.

- In terms of contracting, the Trust is not in arbitration with any of its commissioners. The inflation uplift has been achieved, and inward investment secured on key national priorities relating to early intervention in psychosis and CAMHS, as well as additional investment for S136 police liaison in Calderdale and Kirklees. The focus is now on agreeing deliverable and attainable Commissioning for Quality and Innovation (CQUIN) targets.
- In relation to 0-19 services in Barnsley, the Trust has issued a formal statement and informed stakeholders of its position. The current contract has been extended by three months to 30 June 2016. Barnsley Council's statement highlights the level of Trust overheads and the Trust will ensure that the clinical aspects of its position are fully understood.
- CAMHS are improving; however, they continue to be an area of concern. A report from the Children's Society, based on information from 2014/15, has been published and a meeting has been arranged, involving the Chair of the Trust, to demonstrate the progress made since then. The position continues to be monitored at Board level.

JF reported back from the shadow board meeting the previous day. Ten people were selected and it was a very positive and constructive meeting. The group will shadow the strategy meeting in May and the public board meeting in June.

ABe reported that the Trust has provided assurance to Trust Board (following a short meeting on 18 April 2016 involving the Chair, Deputy Chair, interim Chief Executive, Medical Director, interim Director of Finance and Director of Human Resources) and to the Department of Health that it has robust and effective plans in place to address any pressures caused by the junior doctors planned industrial action. The Trust has relatively few junior doctors and its services do not particularly rely on junior doctors in contrast with trusts in the acute sector. Plans are in place, therefore, to ensure junior doctors' work is not scheduled for the periods of industrial action or that alternative cover is provided. To date, there has been minimal impact to the Trust's planned services. Two-thirds of junior doctors took part in the action on 26 and 27 April 2016. Robust contingency plans were in place and there was very little disruption to services.

TB reported that the CQC is still working to its original timescales with the Trust receiving a draft report in early May 2016 and the final report on 7 June 2016. No further visits have been made to services or requests for information received.

IB confirmed that the strategy meeting in May would focus on how the Board works together using an external facilitator. This will include a session on the draft CQC report.

## TB/16/27 Strategic overview of business and associated risk (agenda item 6)

AF took Trust Board through the report and comments were invited from Directors.

- JF commented that it might be useful for the Trust to consider external factors relating to the European Union/US trade agreement and the impact of the reduction in funding nationally for training, and internal relating to engagement with the medical workforce.

- CD commented on feedback from Middleground relating to transformation 'happening' to staff with little or no engagement and it is important that this is a 'bottom up' process. Alan Davis (AGD) responded that this is a key strand in the staff engagement strategy.

The report was noted by Trust Board.

## TB/16/28 Audit Committee annual report 2015/16 (agenda item 7)

Laurence Campbell (LC) introduced this item and particularly highlighted the re-appointment of KPMG as the Trust's internal auditor for a further year supported by a process for a tender exercise during 2016.

**It was RESOLVED to RECEIVE the report and to SUPPORT the view that the Committee can provide assurance that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that Committees meet their terms of reference, their workplans are aligned to the risks and objectives of the organisation, and they can demonstrate added value to the Trust.**

## TB/16/29 Performance reports month 12 2015/16 (agenda item 8)

TB/16/29a Quality performance report (agenda item 8.1)

TB highlighted the following.

- The visit from the Nursing and Midwifery Council, which provided a positive response in relation to the Trust's arrangements.
- There is significant pressure in some in-patient services in Wakefield in relation to recruitment and retention of staff. Mitigating action is in place to manage any risk.
- The first meeting of the internal risk panel supported a revised approach to managing serious incidents processes to ensure there is focus in the right areas.
- The Trust is at the lowest risk rating for CQC intelligent monitoring.

AGD commented that the Trust is retaining momentum in relation to mandatory training and other HR indicators following the CQC visit and continued monitoring will take place through the Remuneration and Terms of Service Committee.

In response to a comment from the shadow Board, AGD confirmed that exit interviews are undertaken and work is underway to offer enhanced interviews, including the opportunity for discussion in a more confidential setting.

CD commented on the Trust's position in relation to the agency cap and sought assurance that this would be maintained. JC responded that, in 2016/17, the cap is significantly lower than expenditure in 2015/16. This represents a real challenge for the Trust in this financial year. This is a focus for the Executive Management Team (EMT) and fully integrated in monitoring processes through the Operational Requirement Group. The implications of exceeding the cap are currently not clear. IB suggested inclusion on the organisational risk register. CD commented that there is a distinction between the cap and actual spend and she would want to see some concerted action to reduce spend on agency staff. AF responded that the Trust needs to understand what drives spend on agency staff and the action the Trust can take to address this.

CJ asked how the end-of-year performance position impacts on what is reported in 2016/17. AF responded that there is a review through EMT in relation to what is key to the Trust in terms of its objectives and what should, therefore, be reported. A draft report will be circulated to Trust Board in May 2016 and will include, for example, revised reporting on

CAMHS and sickness absence. IB commented that performance reporting must be in a form that supports the Trust to take action and helps Trust Board make decisions. RC commented that she would like to see an assessment of whether performance exceeds risk tolerance and, therefore, what is important for scrutiny at Board level. CJ added that there should be more emphasis on 'so what' and the implications of non-achievement.

TB/16/29b Finance report (agenda item 8.2)
JC advised the following.

- The Monitor risk rating has returned to level 4 at the year-end as a result of the sale of an asset prior to the month-end.
- Under-performance on the cost improvement programme is in line with previous reporting.
- There has been an under-delivery on CQUINs and this has been recognised during negotiations with commissioners to ensure achievability in 2016/17.
- Over 96% of non-NHS invoices have been paid on time.

IB commented that, in 2016/17, he would wish to see financial reporting in conjunction with other performance. It should not be the focus for Trust Board but considered in the round.

TB/16/29c Customer services report Q4 2015/16 (agenda item 8.3)
LC asked if there were any themes behind the increase in complaints in CAMHS. DS responded that most related to access and environment and she would expect this to fall following the move the Laura Mitchell House in Halifax.

RC asked what proportion of complaints is upheld. DS responded the Trust considers every issue and complaint raised to be valid and it is investigated. There is no 'right' or 'wrong' and, therefore, the terminology 'upheld' is inappropriate. If an individual is dissatisfied with the Trust's response, they can raise with the Parliamentary Health Service Ombudsman. RC commented that, whilst she appreciated this, she would like a view of the spectrum of complaints and whether Trust Board should have any concerns. DS responded that it was very much a personal perspective and would be subjective to report in a meaningful way; however, she would review if and how this could be reported. IB added that it would also very much depend on the definition of 'upheld'. He would find some analysis useful, however.

IB also commented that, although he welcomed this form of reporting, he wondered what 'good' would look like. He asked if there could be some form of benchmarking or quality assessment to assist in interpretation of numbers. It was agreed to receive a more detailed report on one particular area at each meeting and an example would come to Trust Board in July 2016.

TB/16/29d Exception reports and action plans – Risk assessment of performance targets, etc. (agenda item 8.4(i))
LC asked for an assessment of the shortfall on CQUIN performance. AF clarified that the current risk assessment is £800,000 for 2016/17 and work will be undertaken during the year to reduce this figure.

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

TB/16/29e Exception reports and action plans – Annual report on planned visits (agenda item 8.4(ii))
In introducing this report, TB commented that this is one part of delivering the governance framework and it gives services the opportunity to take stock, identify what they do well and

identify areas for improvement. The programme represents a mix of routine and risk-based visits. Comments and questions were invited from Trust Board.

- RC commented that this was a good process, which adds value in terms of both process and outcomes. She would welcome a verbal briefing for people new to the process.
- CD asked whether risks identified were followed up. TB responded that they are followed up immediately during the visit if appropriate or within defined timescales.
- LC asked if there is a similar level of recording of incidents on DATIX across services. TB acknowledged that there is a difference. Higher demands on services and higher levels of acuity mean that risk tolerance tends to be higher and the threshold for reporting higher. Work is ongoing with service to address this through training and awareness.
- CJ asked if grading is helpful or if it gets in the way of improvement. TB responded that the original aim was to ensure services are ready for and understand the CQC process. Experience is that services tend not to take as much note of the gradings. Whether this impacts on driving improvement is not clear.
- CJ asked whether weekend visits are included in the programme. TB responded that evening and night visits are included and he will look to include weekend visits.
- IB asked that 'good with concerns' is taken from the ratings as it indicates an inability to agree an actual outcome consistent with CQC ratings.
- TB confirmed that, where visits find that actions from previous visits have not been actioned or completed, actions are escalated to general manager/deputy director level to ensure actions are taken forward in a timely manner.

**It was RESOLVED to RECEIVE the report.**

TB/16/29f Exception reports and action plans – Volunteer accreditation (agenda item 8.4(iii))
IB asked if there tended to be a backlog in matching. DS responded that the process ensures volunteers are matched to the right role and the Trust does keep in touch with individuals during this time.

**It was RESOLVED to NOTE the report.**

TB/16/29g Exception reports and action plans – Well-led review action plan (agenda item 8.4(iv))
AF commented that the Trust has made good progress in meeting the actions agreed in response to the recommendations. Whilst it has aimed to meet the timescales agreed by Trust Board, this has not always been possible.

**It was RESOLVED to NOTE the report.**

TB/16/29h Exception reports and action plans – Trust Board self-certification – compliance with Licence conditions (agenda item 8.4(v))
**It was RESOLVED to CONFIRM that Trust Board was able to make the required self-certification in relation to compliance with the terms of the Trust's Licence.**

TB/16/29i Exception reports and action plans – Trust visual identity (agenda item 8.4(vi))
The revised visual identity was welcomed as an innovative and inclusive approach. IB commented that there was a risk in being the first to comply with new national guidelines and in being used as a national case study. Kate Henry (KH) responded that, although there could be an element of financial challenge, she assured Trust Board that this will be implemented with minimum cost. IB was also concerned that the Trust would be asked to change its new identity. He commented that the Trust cannot afford any after the event criticism and wanted confirmation that the approach was supported by NHS England. KH responded that there had been consultation throughout the process with NHS England and

the Trust will not implement any changes unless formally signed off by NHS England. AF added that there will be a managed introduction internally and externally, and with stakeholders. JF asked if there could be clarity on how much this has cost. KH responded that £3,000 had been spent, including an amount to an external agency on the creative concept. IB also asked for the detail of the cost associated with the re-brand.

**It was RESOLVED to SUPPORT the revised visual identity.**

## TB/16/30 Items for approval (agenda item 9)

TB/16/30a Information Management and Technology Strategy (agenda item 9.1)

LC asked whether the STPs would impact on the Strategy. AF responded that digitisation is a key workstream in both STPs in relation to how services are accessed and sharing of information. The Trust is fully involved and this has been considered in development of this Strategy.

CJ asked if it was costed and affordable. IB added that he was comfortable this was within budget; however, this was an area that may require more capital funding in future. AF responded that it was included in the capital plan and frontloaded in the next few years.

LC commented that there is a difficult balance between quality and security and he asked that security is in place where it is needed. AF responded that information governance arrangements should not be a barrier to access or to sharing information. She confirmed that service users are engaged and involved in shaping and implementing systems.

**It was RESOLVED to APPROVE the Strategy.**

## TB/16/31 Monitor Q4 2015/16 return (agenda item 10)

AF advised that the Information Commissioner's Office will take no further action at this point in relation to the Trust's undertaking; however, this will remain under review. A provision for a possible fine was made in the accounts. Her recommendation is that this is retained given that the undertaking remains in place. This represents a post-balance sheet event reported to the Auditor. Trust Board supported this approach.

*Julie Fox left the meeting at this point.*

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

## TB/16/32 Assurance framework and risk register (agenda item 11)

RC commented that she would find a one page 'heat map' useful providing an overarching view of where Trust Board should focus its scrutiny. LC commented that it would be useful to combine both into one document. DS agreed to set up a small sub-group to look at how the assurance framework and risk register can be presented to Trust Board in Q1 of 2016/17 in July 2016.

**It was RESOLVED to NOTE the controls and assurance against corporate objectives in Q4 2015/16 and to NOTE the key risks for the organisation.**

AGD advised that the Trust's Fire Officer has raised a concern regarding an increased risk as a result of the Trust's smoking policy. ABe responded that there is a need to ascertain whether the level of fire-related incidents has changed and whether these are related to the Trust's smoke-free policy. The policy itself should not be the focus of any review; it should

be on safety in relation to fire on in-patient units. The EMT was asked to make an assessment once the review is complete.

**TB/16/33 Date and time of next meeting (agenda item 12)**

The next meeting of Trust Board will be held on Thursday 28 June 2016 in rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR.

**Signed …… Date ……**

# Trust Board 28 June 2016
# Agenda item 5

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| **Title:** | **Care Quality Commission inspection update** |
| **Paper prepared by:** | Director of Nursing, Clinical Governance and Safety |
| **Purpose:** | To provide an update to Trust Board in relation to the outcome of the Care Quality Commission (CQC) inspection in March 2016. |
| **Mission/values:** | Honest, open and transparent, person first and in the centre, improve and be outstanding, relevant today and ready for tomorrow and families and carers matter. |
| **Any background papers/ previously considered by:** | Update reports have been provided to both Trust Board and the Clinical Governance and Clinical Safety Committee. |
| **Executive summary:** | The Trust was subject to a comprehensive inspection by the Care Quality Commission (CQC) in the week beginning 7 March 2016. As a learning organisation, the Trust's values are at the heart of everything it does, and the CQC visit and its independent view of services was welcomed.<br><br>The Trust received its draft reports, which consist of fourteen individual service reports and one overall report for the organisation. The reports were reviewed for factual accuracy over the last few weeks and a response sent to the CQC on 10 June 2016.<br><br>In addition to the accuracy check, the reports have been reviewed by the BDU teams to identify any areas that required immediate attention. There were some areas where this has been the case and action has been taken.<br><br>The final report was received on 20 June 2016 and will be published on 23 June 2016. All of our services were found to be caring and the reports highlight how our staff treat people with kindness, care and compassion.<br><br>Across the 14 service reports, more than 70% of the individual ratings are 'Good' (green). In addition, the CQC highlighted 'Outstanding' areas of care, including the effectiveness of our end of life services and the caring nature of our community services for children, young people and families. No scores of 'inadequate' were given, we were given no immediate compliance actions and there were no return visits from the CQC.<br><br>A snapshot of the ratings for information is included in the associated presentation. There are areas that require improvement and these are primarily linked to access issues in child and adolescent mental health services and psychological therapies, elements of staffing, internal governance and RiO. All of these are areas where we have plans in place to support improvement.<br><br>The action plan required by the CQC is being completed and will be submitted by the 9 August 2016 deadline required.<br><br>This action plan will be monitored through the Clinical Governance and Clinical Safety Committee.<br><br>This external validation and independent view of our strengths and areas for |

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| | action is very helpful. The CQC overall has suggested that we are rated as 'Requires improvement'. As a learning organisation, we embrace this and will keep doing the 'Good' and 'Outstanding' things and improving those that are in need of improvement.<br><br>Our Monitor governance rating remains 'Green' and we have a financial sustainability risk rating of 4 (the strongest rating possible), as set by NHS Improvement.<br><br>A Quality Summit will be held at the end of July/early August 2016. This meeting will bring together partners from across the health and care system, including the Members' Council, to present the report and the Trust's response. There will also be the opportunity for stakeholders to ask the Trust or the CQC any further questions. More information will be provided about the Quality Summit as soon as it is available.<br><br>The Chief Executive has written to the Members' Council and stakeholders to show appreciation for the ongoing support, both throughout the inspection process and in the future as the Trust continues to learn and improve the care provided to people who use Trust services.<br><br>The attached presentation has been utilised during our staff briefing events and includes a snapshot of the service ratings. A frequently asked questions sheet is also attached for information. |
| **Recommendation:** | **Trust Board is asked to NOTE the update report and consider the next steps required.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Our CQC reports

**22 June 2016**

With **all of us** in mind.

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# Background

The Care Quality Commission (CQC) monitor, inspect and regulate health and social care services.

They routinely inspect health and social care services to make sure they're:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Our inspection

We welcomed the inspection in March and the independent view of our services.

It’s an opportunity to continue improving our services for local people.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Our inspection

The CQC looked at a significant amount of written information e.g. reports, meeting minutes, statistics, action plans, policies and strategies.

They also spoke to people who use our services, their carers and the general public, as well as partner organisations.

676 comments were received directly.

- 76 inspectors
- 5 days
- 100% of our inpatient services
- 32% of our services in the community

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Our inspection

Our rating is made up of 14 separate reports:

- There is one report for each type of service
- 350+ pages in total across the 14 reports
- There is also a summary report.

It reflects how complex we are:

- Over 230 individual services
- Making nearly 1 million contacts each year
- Across four geographic districts.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# The headlines

Without exception, all of our services were found to be caring.

The report highlights how staff treat people with kindness, care and compassion.

With **all of us** in mind.

# South West Yorkshire Partnership NHS

NHS Foundation Trust

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Community health services for children, young people and families | Good | Good | Outstanding ☆ | Good | Good | Good |
| Community health services for adults | Good | Good | Good | Good | Good | Good |
| Community health inpatient services | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Outstanding ☆ | Good | Good | Good | Good |
| Community-based mental health services for adults of working age | Good | Good | Good | Requires improvement | Good | Good |
| Community mental health services for people with learning disabilities or autism | Good | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Community-based mental health services for older people | Good | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Specialist community mental health services for children and young people | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Long stay / rehabilitation mental health wards for working age adults | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Wards for older people with mental health problems | Requires improvement | Good | Good | Good | Good | Good |
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Mental health crisis services and health-based places of safety | Good | Good | Good | Good | Good | Good |
| Forensic inpatient / secure wards | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Wards for people with learning disabilities or autism | Good | Good | Good | Good | Good | Good |

Across these 14 reports, more than 70% of the individual ratings are ‘Good’ (green).

Overall there are eight ‘Good’ ratings across all of our community, mental health and learning disability services.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# The headlines

‘Outstanding’ areas of care:

- Effectiveness of our end of life services
- Caring nature of our community services for children, young people and families.

And:

- No scores of ‘Inadequate’
- No immediate compliance actions
- No return visits from the CQC.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Areas that require improvement

Areas that require improvement include:

- Access issues in CAMHS and psychological therapies
- Elements of staffing
- Internal governance
- RiO

These are all areas where we are getting better and already have plans to improve.

We know that there are challenges, for example with staffing in some places, and this is reflected in the report.

These areas were also reflected in our recent staff listening events.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Our overall rating

Our overall rating is ‘Requires improvement.’

Let’s embrace this learning:

Keep doing the ‘Good’ and ‘Outstanding’ things.

Improve those things that are in need of improvement.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Monitor

Our Monitor governance rating remains ‘Green’.

We have a financial sustainability risk rating of 4 (the strongest rating possible), set by NHS Improvement.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Take pride

We need to be open, honest and transparent.

We need to continue to improve our services for people who need them and learn from our ‘Good’ and ‘Outstanding’ practice, as identified by the CQC.

Be proud that, without exception, you were found to be caring.


With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# We need to be relevant today and ready for tomorrow

We expect our Quality Summit to be held towards the end of July. This will bring together partners from across our health and care system.

We're making sure that our action plan for improvement addresses all of the issues raised in the reports.

Our focus is on continuing to improve the services we provide for local people.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Thank you

Keep people in the centre
as we continue with
further improvements.

Thank you for all the effort
that went into the inspection.

Thank you for everything you do,
every day.

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Any questions?

Full reports will be available when published on the intranet and our website.

With **all of us** in mind.

With **all of us** in mind.

# CQC inspection and ratings

## Frequently asked questions - June 2016 (v0.2)

## Background

### Who are the CQC?

The Care Quality Commission (CQC) monitor, inspect and regulate health and social care services. They routinely inspect health and social care services to make sure they provide people with safe, effective, compassionate, high-quality care.

### What does a CQC inspection cover?

Services are judged against five key questions. Are they:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

The CQC then rate individual service areas to help people understand where care is outstanding, good, requires improvement or inadequate.

### When did the CQC visit our Trust?

The CQC carried out a comprehensive inspection of our Trust in March 2016. Seventy-six inspectors went into our services over a five day period.

### Which services did they visit?

We have over 230 individual services. The CQC visited all our inpatient services and 32% of services that work in the community.

The CQC couldn't physically visit every single service. Instead, they went to a very broad representation and spoke, in depth, to staff from across our services and our professional groups.

### How else did the CQC get information?

They looked at a significant amount of written information, from reports and meeting minutes to statistics, action plans, policies and strategies.

Alongside this, they spoke to people who use our services, their carers, the general public and partner organisations. People also had the chance to send their comments direct to the CQC and 676 comments were received.

### Why does the CQC's opinion matter?

As a learning organisation we welcome the inspection and independent view of our services. This external validation and independent view of our strengths and areas for action is very helpful. We welcome any opportunity to continue improving our services for local people.

## Our results

### How is our rating decided upon?

Our rating is made up of 14 separate reports covering our service lines and a summary report. The 350+ pages of these 14 reports indicate the complexity of our organisation; we have over 230 individual services making nearly 1 million contacts each year across four geographic districts.

### What did the CQC think of our services?

Across our 14 reports, more than 70% of the individual ratings are 'Good' (green), as shown:

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Community health services for children, young people and families | Good | Good | Outstanding ☆ | Good | Good | Good |
| Community health services for adults | Good | Good | Good | Good | Good | Good |
| Community health inpatient services | Good | Good | Good | Good | Good | Good |
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| Community mental health services for people with learning disabilities or autism | Good | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Community-based mental health services for older people | Good | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Specialist community mental health services for children and young people | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
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| Mental health crisis services and health-based places of safety | Good | Good | Good | Good | Good | Good |
| Forensic inpatient / secure wards | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Wards for people with learning disabilities or autism | Good | Good | Good | Good | Good | Good |

**Did the CQC find anything exceptionally good or really bad?**

The CQC highlighted ‘Ooutstanding’ areas of care, including the effectiveness of our end of life services and the caring nature of our community services for children, young people and families.

Overall there are eight ‘Good’ ratings across all of our community, mental health and learning disability services.

No scores of ‘Inadequate’ were given, we weren’t given any immediate compliance actions and there were no return visits from the CQC.

**What did the CQC think of our staff?**

Without exception, all of our services were found to be caring and the reports highlight how staff treat people with kindness, care and compassion.

**So, what’s our overall rating?**

The CQC overall has suggested that we are rated as ‘Requires improvement’. We will embrace this learning and will keep doing the ‘Good’ and ‘Outstanding’ things and improving those that are in need of improvement.

**What does ‘Require improvement’ actually mean?**

The CQC’s definition is that some aspects of the Trust’s services are not performing as well as they should be. These are clearly listed in each report and we have already made good progress in addressing the improvements required.

**What needs to be improved?**

We need to improve the way people access our child and adolescent mental health services (CAMHS) and our psychological therapies, as well as address elements of staffing and internal governance (the way we manage process). These are all areas where we are getting better and we have plans to improve. We know there are challenges, for example around staffing in some areas, and this is reflected in the report.

**Did the CQC tell us anything we didn’t know?**

The mark of a good organisation is one that is self-aware. There were very few surprises in our reports - they reflect the areas we are already working on and have action plans in place for.

**Are our services safe?**

Yes. The key area highlighted as requiring improvement is around staffing. This is based on our ability to meet our locally set levels. As there is no national safe staffing standard for mental health, we developed an ‘optimum staffing tool’ that covers all elements of delivering high quality care, not just safety. We haven’t always been able to staff to this level on every service and every shift. We have though, ensured services are safe. We’ll continue to help lead the way in understanding optimum staffing levels and we’ll keep sharing this approach with other Trusts.

**Why then do we 'Require improvement' on our safety?**

It's important that we don't draw a conclusion that we're failing in the areas where we have been asked to improve. Our rating doesn't, for example, mean our services are unsafe - the CQC themselves describe a 'Requires improvement' rating as where they:

> ***"…believe that the providers concerned have the ability and the capacity to improve the safety of the care they provide… in contrast, an inadequate rating is a strong indication that care is unsafe".***

Safety is our first priority and our extra investment in safer staffing this year is testament to that.

**Are our services effective?**

Yes. Issues relating to Mental Health Act (MHA) training are being addressed - we've made it mandatory. We are also addressing issues with our clinical system RiO.

**Are our services responsive?**

We're working hard on this and have already had great success with reducing waiting lists. For example, our child and adolescent mental health service (CAMHS) in Barnsley has reduced waiting times for assessments from 14 to 5 weeks. We are confident we can apply this learning to the areas highlighted by the CQC.

**Are our services well-led?**

Yes. The CQC found some areas of our internal governance (the way we manage our processes) needed some improvement and we are committed to getting this right.

**Are our services caring?**

Without exception, yes. The CQC observed how our staff treat people with kindness, dignity, compassion and respect. This was backed up by many of the comments they received from people who use our services and their carers.

## Next steps

**What happens next?**

As a learning organisation, we embrace the CQC reports. We will keep doing the "Good" and "Outstanding" things and improve those things that are in need of improvement.

We will be taking part in what the CQC call a 'Quality Summit'. This is an event where we come together with the CQC, our partner organisations, commissioners and Healthwatch bodies to look at the inspection reports and discuss the improvements that need to be made, along with those already made since the inspection took place.

We expect that the Quality Summit will take place towards the end of July 2016.

**Will we be developing action plans?**

There were very few surprises in our reports - they reflect the areas we are already working on and have action plans in place for. This is good because it means we can continue to

build on the work we're already doing. We'll make sure there's action plans for everything they have highlighted as an area where we could improve.

**How can people be assured that the Trust is taking the findings seriously?**

The inspection process and the learning from it will be shared and understood from team and ward level right through to our Board and Members' Council. Those services that are rated 'Requires improvement' will be supported by the organisation to improve, and progress will be tracked through to Board level.

**Will we be kept up to date?**

Yes, we'll share our action plans and how we are getting on with them. If you've got any questions, just drop us a line.

**What's most important now is that we continue to improve our services for people who need them.**

# Trust Board 28 June 2016
# Agenda item 6.1

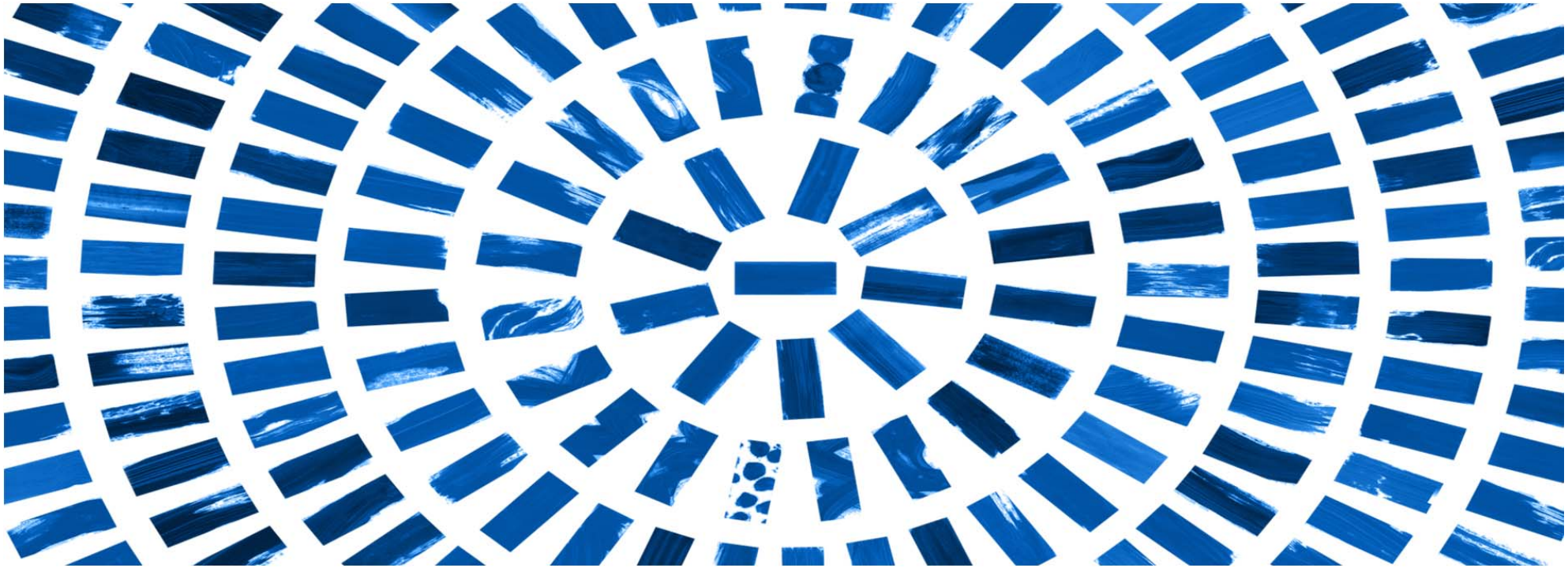
| | |
|---|---|
| **Title:** | **Performance report month 2 2016/17** |
| **Paper prepared by:** | Director of Finance |
| **Purpose:** | To provide Trust Board with the integrated performance report at month 2 2016/17. To raise any specific issues relating to achievement of performance targets with Trust Board and enable a discussion to take place regarding any actions that need to be taken to address these issues. To outline the changes to the report and the future developments to be made in the next few months. |
| **Mission/values:** | Performance reporting supports the Trust's mission and values |
| **Any background papers/ previously considered by:** | The performance report was considered by the Executive Management Team on 23 June 2016 |
| **Executive summary:** | <u>Changes made to the report</u><br>• The format of the report has been revised in conjunction with representatives from Non-Executive Directors. The vision is to have a single report that plots a clear line between objectives, priorities and activities. The intention is to build more flexibility and depth into the report that can showcase the breadth of the organisation and its achievements as well as meeting the requirements of regulators.<br>• In addition to the format, there have been some changes to the report.<br>- Key areas such as quality, regulatory, workforce, finance and contracting have been grouped into their own sections.<br>- A further section covering the localities has been added and a section on transformation will be added next month.<br>• Further developments will take place over the next few months to produce a report that provides a comprehensive view of the organisation. Focus will be applied to both providing assurance of how areas of concern will be managed and mitigated and taking a pro-active approach to identifying any potential hotspots and issues at an early stage.<br>• Focus will also be applied to how the report and associated processes enable good triangulation of finance, performance, activity and quality data.<br>• Mental Health Act/Mental Capacity Act training and flu vaccination uptake will be added to the workforce data.<br><br><u>Summary of Month 2 performance</u><br>• The vast majority of performance targets are being achieved.<br>• The most significant risk is related to the achievement of improving access to psychological therapies (IAPT) treatment within six weeks of referral. Whilst an improving trajectory, there is a risk of under-achievement in quarter 1 which would represent the third consecutive quarter under the NHS Improvement target. The main issue relates to availability of the required workforce. Actions are in place to ensure |

| | |
|---|---|
| | improved performance against this target and detail can be seen in the main body of the report. Very recent performance is above the target threshold and this needs to be maintained on an ongoing basis.<br>• A sickness level of 4.7% is above target of 4.4%. The highest levels of absence are in Wakefield and Specialist Services. |
| **Recommendation:** | **Trust Board is asked to REVIEW the integrated performance report and discuss any specific issues arising from it. Trust Board is also asked to PROVIDE feedback on the new format and vision for the report going forward.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Integrated Performance Report

## Strategic Overview



**May 2016**

With **all of us** in mind.

# Table of Contents

# Introduction

Welcome to the Trust's new style Integrated Performance Report: Strategic Overview for May 2016, information unless stated. The format of the report has been revised in conjunction with representatives from our Non-Executive Directors. The vision is to have a single report that plots a clear line between our objectives, priorities and activities. The intention is to build more flexibility and depth into the report that can showcase the breadth of the organisation and its achievements as well as meeting the requirements of our regulators and providing an early indication of any potential hotspots and how these can be mitigated. We will also strive to ensure that there is appropriate ownership and accountability for the delivery of all our performance metrics.
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 and will contribute towards streamlining the number of different reports that the board receives

The Trusts three strategic objectives are:
• Improve people's health and reduce health inequalities
• Improve the quality and experience of care
• Improve our use of resources

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Strategic Summary
• NHS Improvement (formerly Monitor)
• Quality
• Locality
• Transformation
• Finance
• Contracts
• Workforce

Work will be undertaken in the coming months to further align the report to the delivery of the strategic objectives. Specific focus will be applied on the strengthening of reporting of our quality measures on a monthly and quarterly basis. This will continue to 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
Performance reports are available as electronic documents on the Trusts intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

As this report is under development, the Trust would welcome any feedback.

| Section | KPI | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS Improvement Compliance | NHS Improvement Governance Risk Rating (FT) | Green | Green | Green | | | | | | | | | | |
| | NHS Improvement Finance Risk Rating (FT) | 4 | 4 | 4 | | | | | | | | | | |
| CQC | CQC Quality Regulations (compliance breach) | Green | Green | Green | | | | | | | | | | |

**Lead Director:**

**Narrative:**

The integrated performance report shows a good performance rating, with achievement of the majority of indicators at May 2016.
Correlation of quality information (including patient experience and safety related measures), performance, finance, workforce and health and safety information has taken place and did not identify any significant areas of concern other than those identified below.

As work is undertaken to refine developments to track performance against 16/17 objectives, these may be incorporated into this report.

Areas to Note:

NHS Improvement - risk is associated with achievement of the IAPT Referral to treatment within 6 weeks indicator at the end of quarter 1. There is a risk that the target will not be achieved for the third consecutive quarter. Details can be seen in the NHSI section of the report.

Workforce - high sickness levels can be seen in Specialist and Wakefield BDU during May 16. Further detail can be seen in the workforce section of the report.

Achieving Better Access to Mental Health Services by 2020 - Access Targets for Early Intervention for Psychosis and Improving Access to Psychological Therapies - The Trust continues to achieve against the national thresholds, with the exception of IAPT 6 weeks indicator as outlined above.
The Trust continues to perform well against the national standards for Delayed Transfers of Care from an inpatient setting and 18 weeks Referral to Treatment for applicable services. Detail of performance and actions in place to support trajectory of improvement can be see in the NHSI section of the report.

NHS Improvement (was Monitor) considers the ability of NHS foundation trusts to meet selected national standards for access and outcomes to be an important indicator of the effectiveness of the organisation's governance. Performance against the measures that are applicable to us is; undertaken locally on a monthly basis and reported externally to NHS Improvement on a quarterly basis.

| Section | KPI | Target | Q1 2015/16 | Q2 2015/16 | Q3 2015/16 | Q4 2015/16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Year End Forecast Position * | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Max time of 18 weeks from point of referral to treatment - incomplete pathway | M | 92% | 98.35% | 98.76% | 98.80% | 98.11% | 97.83% | 97.95% | | | | 4 | |
| Delayed Transfers Of Care | M | 7.50% | 2.02% | 1.88% | 2.93% | 2.33% | 4.04% | 1.88% | | | | 4 | |
| % Admissions Gatekept by CRS Teams | M | 95% | 95.51% | 97.29% | 95.69% | 98.32% | 96.80% | 96.83% | | | | 4 | |
| % SU on CPA Followed up Within 7 Days of Discharge | M | 95% | 98.66% | 97.97% | 95.50% | 97.44% | 95.12% | | | | | 4 | |
| % SU on CPA Having Formal Review Within 12 Months | M | 95% | 97.92% | 98.44% | 98.56% | 96.60% | 96.10% | 82.34% | | | | 4 | |
| Data completeness: comm services - Referral to treatment information | M | 50% | 100% | 100.00% | 100.00% | 100% | 100% | 100.00% | | | | 4 | |
| Data completeness: comm services - Referral information | M | 50% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | | | | 4 | |
| Data completeness: comm services - Treatment activity information | M | 50% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | 96.80% | | | | 4 | |
| Data completeness: Identifiers (mental health) | M | 97% | 99.62% | 99.54% | 99.45% | 98.48% | 98.80% | 98.40% | | | | 4 | |
| Data completeness: Outcomes for patients on CPA | M | 50% | 77.63% | 76.97% | 78.58% | 75.58% | 75.69% | 75.09% | | | | 4 | |
| Compliance with access to health care for people with a learning disability | M | Compliant | Compliant | Compliant | Compliant | Compliant | *Compliant* | *Compliant* | | | | 4 | |
| IAPT - Treatment within 6 Weeks of referral | M | 75% | 77.84% | 75.91% | 71.62% | 70.51% | 74.04% | 74.19% | | | | 4 | |
| IAPT - Treatment within 18 weeks of referral | M | 95% | 99.09% | 99.15% | 99.37% | 98.09% | 98.60% | 98.39% | | | | 4 | |
| Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops | M | 50% | N/A | N/A | 85.19% | 86.00% | 73.91% | 78.26% | | | | 4 | |

** See key included in glossary.*

**Lead Director:**
**Narrative:**
**Areas of concern:**

IAPT - Treatment within 6 weeks of referral: The under performance is attributed to the Barnsley and Calderdale IAPT services and is mostly attributed to the number of Psychological Wellbeing Practitioner vacancies within the Barnsley team. The service have put mitigating actions in place to assist with reducing the waiting time. This includes an ongoing recruitment plan and work being undertaken in conjunction with HR related to training places. The issue regarding number of training places allocated has been raised with Health Education England (HEE). Capacity of existing staff has been increased, close monitoring of performance is being undertaken both internally and with the CCG which is playing a supporting role. On review of the waiting times for those entering treatment during May 16, 85.3% entered within 6 weeks which evidences improvements in current waiting times (April 16 80.3%). However, due to the construct of this indicator (counting those completing treatment), improvement will take time to filter through. The Calderdale IAPT service did not achieve the 75% criteria during May 16, and this relates mostly to those entering the High Intensity pathway and is also linked to capacity. The service has made some adjustments to align the access process to that of the Kirklees service and for those entering treatment during May, 96% entered within 6 weeks. A targeted piece of work is being undertaken which will focus on how this can be resolved in the short term but also includes medium and long term plans.

% Service Users on CPA having formal review within 12 months - Performance has dipped for the month of May 16. The reported performance reflects a forecast position based on the actual position as at the end of May 16. Performance is anticipated to improve by the end of quarter 1 due to a number of reviews already been scheduled and any outstanding reviews being identified to take place within the required timescales. There are also a number of data quality issues contributing to the current reported performance that are being actioned and will contribute to the anticipated achievement of the target at the quarter end.

NHS Improvement expects NHS foundation trusts to establish and effectively implement systems and processes to ensure they can meet national standards for access to healthcare services. Performance against a number of these standards is included in the assessment of the overall governance of a trust. Breach of a single metric in three consecutive quarters or four or more metrics breached in a single quarter will trigger a governance concern. Based on April and May data there is high risk of this not being achieved at the end of quarter 1.

## **Quality Headlines** (& CQUINS performance on a quarterly basis)

| Section | KPI | Target | Q1 2015/16 | Q2 2015/16 | Q3 2015/16 | Q4 2015/16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Year End Forecast Position * |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | 6 | 0 | 3 | 0 | 0 | 0 | 0 | | | | 4 |
| C-Diff | C Diff avoidable cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 4 |
| Outcomes | % SU on CPA in Employment | 10% | 7.18% | 7.55% | 7.37% | 7.25% | 6.89% | 6.96% | | | | 1 |
| | % SU on CPA in Settled Accommodation | 60% | 64.44% | 62.81% | 64.09% | 62.26% | 60.04% | 67.89% | | | | 4 |
| Complaints | % Complaints with Staff Attitude as an Issue | < 25% | 14% 23/179 | 13% 20/156 | 14% 20/140 | 15% 31/211 | 8% 4/53 | 23% 12/53 | | | | 4 |
| Service User Experience | Friends and Family Test | TBC | 89.00% | 91.00% | 88.83% | 87.20% | 85% | 84.00% | | | | N/A |

** See key included in glossary*

Further and more detailed reporting of performance against quality and compliance metrics is currently reported via the Strategic Overview Integrated Performance report on a quarterly basis. Work will be undertaken to review monthly reporting to ensure a stronger set of indicators on quality, to cover the three dimensions – experience, outcomes, safety.

Historically we have not reached the target in achieving 10% of CPA service users in employment and the current trajectory does not suggest this will be achieved at year end. The indicator parameters only include clients on CPA, within the age range 18-69 years old - the Trust is currently undertaking a pilot project in Barnsley covering all mental health service users (regardless of CPA status or age) which is focusing on employment, volunteering and training. Further work will be undertaken in the next few months with partners to review this indicator with specific regard to the report parameters and the expected contribution of SWYPFT to the achievement of this indicator going forward.

This section of the report is to be developed during 2016/17 and populated with key performance issues or highlights as reported by each BDU.

**Barnsley BDU:**

· Sickness absence improved to 4.1%.
· Recovery plan for IAPT has been developed and is supported by the CCG.
· Falls waiting times have been reduced from over 3 weeks to less than 2 weeks.
· DTOC for MH services has increased to 12.65%, this is largely related to 7 individuals with reasons for delay relating to awaiting availability/placement in nursing or residential setting.

**Calderdale & Kirklees BDU:**

• Older Peoples Service – 14 day access targets improved in May following reductions in March and April. Sickness in OPS CMHT remains high although all being actively managed.
• Acute services remain under significant pressure with regards to acute admissions.
• Community services – current service model struggling to meet demand, however new model will enable demand to be more effectively managed.

**Forensics BDU:**

· Acuity and physical violence within the forensic services has been a concern, evidenced by an increase in reported incidents of violence. Plans are in place to continue to deliver safe and effective care. Use of temporary staffing will remain high, with additional requirements currently being 10 staff every shift.

· 25 hours structured activity for service users in Newton Lodge remains a challenge, with performance at 88.41% against a target of 100%. Further analysis of the recording and reporting is being undertaken to ensure that activity is captured and that where activity is not undertaken for clinical reasons, this is understood.

**Specialist BDU:**

There has been significant improvement in waiting times for the initial assessment in CAMHS. Work is underway to address the long waits that remain for appointments to commence treatment and for ASD assessment and diagnosis.

**Wakefield BDU:**

· Qualified staffing issues are impacting on capacity within Wakefield Acute Mental Health Wards and admissions are being managed accordingly. Position monitored daily to prioritise staff deployment across BDU, and staff recruited for September cohort.
· Sickness levels in Older Peoples services are being adversely affected by long term absence – this is being proactively managed within the relevant Policy.
· Significant improvements in gatekept admissions over recent months are being sustained within the BDU.

# Overall Financial Performance 2016 / 2017

## Executive Summary / Key Performance Indicators

| | Performance Indicator | Year to Date | Forecast | Narrative |
|---|---|---|---|---|
| 1 | NHS Improvement Risk Rating | 4 | 4 | The Trust has planned for and delivered, a risk rating of 4 in May 2016. It is currently forecast that a rating of 4 will be maintained throughout the year. |
| 2 | Surplus | £0.59m | £1.85m | The year to date position shows a surplus of £589k; this is £145k better than plan. Full year forecast remains in line with plan at £1.85m. This will require use of all contingency, based on current BDU projections and risk associated with CIP delivery, which must be mitigated. |
| 3 | Agency Cap | £1.65m | tbc | NHS Trusts have been set maximum agency spend caps for 2016 / 2017 by NHS Improvement. Expenditure in month 2 is in line with month 1 and based on this tread this cap will be breached. Additional controls and monitoring are to be put in place. |
| 4 | Cash | £25.6m | £23.2m | The cash position is lower than plan at May 2016 mainly due to creditor payments. The forecast position projects the Trust to be back in line with plan from month 3. |
| 5 | Capital | £1.15m | £12.31m | Capital expenditure is marginally under plan as at May 2016. This is due to timing delays in major schemes but these remain forecast to deliver on time and in budget. |
| 6 | Delivery of CIP | £1.32m | £7.17m | Year to date CIP delivery is £0.52m behind plan . Overall the forecast position includes £2.89m of red rated schemes, against which actions must be taken or replacements identified to ensure delivery. |
| 7 | Better Payment | 98% | | This performance is based upon a combined NHS / Non NHS value. We do not currently forecast future performance against this KPI. |

| | |
|---|---|
| Red | Variance from plan greater than 15% |
| Amber | Variance from plan ranging from 5% to 15% |
| Green | In line, or greater than plan |

# Contracting

**Trust Summary by BDU - Current Contract Performance - Position at month 1**

| Contract Variations | In progress | Completed | TOTAL |
|---|---|---|---|
| B BDU | 0 | 0 | £0.0 |
| W BDU | 0 | 0 | £0.0 |
| C BDU | 0 | 0 | £0.0 |
| K BDU | 0 | 0 | £0.0 |
| S DBU | 0 | 0 | £0.0 |
| F BDU | 0 | 0 | £0.0 |
| TOTAL CVs | 0 | 0 | £0.0 |

**CQUIN Performance** **Q1 Forecast based on**

| Quarter | Quarter 1 £000s | Achieved | Variance | M1 Performance | Vari |
|---|---|---|---|---|---|
| Barnsley | £352.6 | | | £352.6 | £0.0 |
| Wakefield | £113.1 | | | £113.1 | £0.0 |
| Kirklees | £105.7 | | | £105.7 | £0.0 |
| Calderdale | £52.2 | | | £52.2 | £0.0 |
| Specialised | £103.1 | | | £103.1 | £0.0 |
| Forensics | £130.8 | | | £130.8 | £0.0 |
| Trust Total | £857.5 | £0.0 | £0.0 | £857.5 | £0.0 |

**CQUIN Performance Year-end Forecast**

| Quarter | Annual £000s | Forecast Achievement | Variance |
|---|---|---|---|
| Barnsley | £1,655.9 | £1,438.4 | -£217.5 |
| Wakefield | £767.2 | £698.6 | -£68.7 |
| Kirklees | £702.3 | £553.7 | -£148.5 |
| Calderdale | £346.7 | £273.4 | -£73.3 |
| Specialised | £500.9 | £473.2 | -£27.7 |
| Forensics | £568.5 | £568.5 | £0.0 |
| Trust Total | £4,541.5 | £4,005.9 | -£535.7 |

**Key Contract Issues - Specialist**

**Calderdale** CAMHs procurement imminent

**Kirklees** 0-19 procurement including CAMHs imminent

**Barnsley: CAMHs c**ontracting discussion returning to main BCCG Contract meetings.

**Wakefield:** Focussed joint work with WCCG to understand CAMHs VfM and service delivery.

**Eating Disorders:** Awaiting draft contract

**Wakefield LD:** community service spec and KPIs currently being finalised. Date for implementation of new model to be agreed following this.

**Key Contract Issues - Barnsley**

**Rotherham & Doncaster MBCs PH** - SWYPFT has agreed to a contract reduction against the Drugs which is a pass through

**0 - 19 Service** - The formal agreement is that BMBC will take services in house from 1st October 2016

**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

**Intermediate Care** - The CCG has informed SWYPFT that it will be going out to tender for the Service. The new Service starting in July 2017

**QIPP Targets & Delivery for 2016/17**

| CCG | Target £000s | Planned £000s | Remainder £000s | RAG |
|---|---|---|---|---|
| Wakefield* | £1,000.0 | £0.0 | -£1,000.0 | |
| Kirklees** | | | | tbc |
| Calderdale | £0.0 | | | |
| TOTAL £000s | £1,000.0 | £0.0 | -£1,000.0 | |

** K includes Specialist LD scheme

**Proposals under the QIPP scheme -**

W - QIPP Cumulative Position for 2014/15/16 shows £1.944m delivered in total.
W - £1m: contract value to remain unchanged - schemes to be developed in conjunction with CCG to deliver target

K - 16/17 **value tbc £xm** in total, across K & Specialist BDUs 1) Reduction on OOA spend for Specialist Rehabilitation & Recovery placements KBDU owned. Reduction in OOA LD Specialist placements Specialist BDU.
C - No requirements

**KPIs and Penalties**

| Commissioner | Penalty £000s | Comment |
|---|---|---|
| Barnsley CCG | £5.3 | MSK as at Mth 1 |

**Key Contract Issues - Kirklees**

**K IAPT:** New reporting from Apr 16 includes 4 indicators aligned to National Contract - Moving to Recovery, Prevalence and Access Waiting Times (6&18 weeks). Prevalence figs reflect HSCIC requirements.
Commissioners keen to align services with external Provider (INSIGHT).

**Key Contract Issues - Calderdale**

C IAPT - As above

**Key Contract Issues - Forensics**

National procurement identified for 2016/17 for Medium & Low Secure MH Services with CAMHS tier 4 likely to be in first lot.

**Key Contract Issues - Wakefield**

WAA transformation – CCG governance documents to be completed and submitted to CCG for approval.

KPIs to be developed and agreed.
Memory clinic – concern over capacity and performance, further information requested by commissioner

Dementia service – tender process expected to start autumn 2016. Commissioner seeking assurance that Trust internal OPS transformation will align with dementia service re-design.

WDH navigators – meeting arranged with WDH to co-produce SLA. Recruitment under way.
Anger management – joint project between CCG and Trust to map pathway and identify gaps in service

QIPP – no schemes identified as yet, priority to find cash releasing schemes

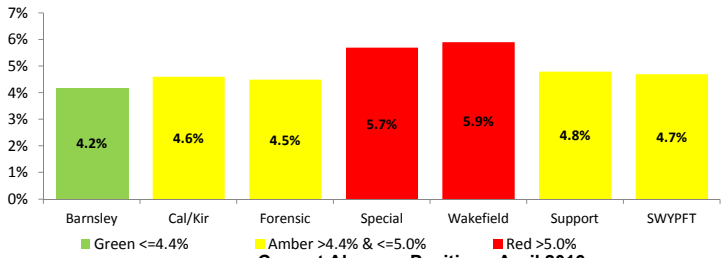
**Key Contract Issues - Health & Wellbeing**

Work is ongoing with Wakefield MDC PH regarding the decommissioning of the Health & Wellbeing Services, excluding Stop Smoking Services during 2016/17

# Workforce

## Human Resources Performance Dashboard - May 2016

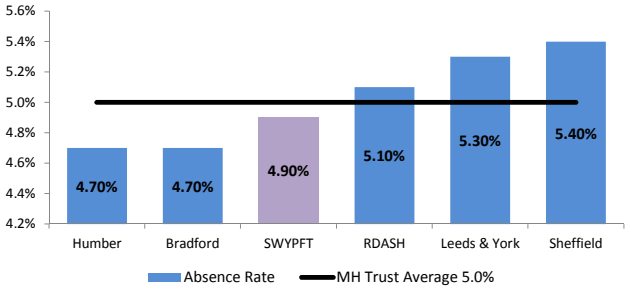
### Sickness Absence




**Current Absence Position - April 2016**

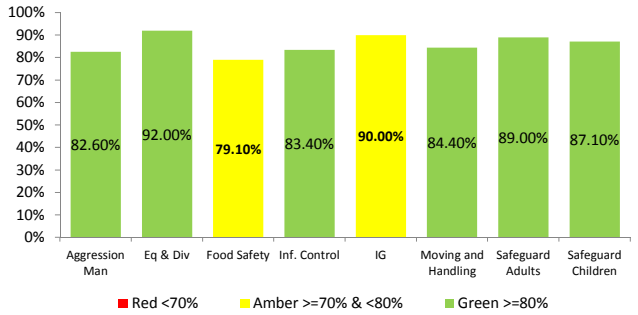
| | Barn | Cal/Kir | Fore | Spec | Wake | Supp | SWYPFT |
|---|---|---|---|---|---|---|---|
| Rate | 4.2% | 4.6% | 4.5% | 5.7% | 5.9% | 4.8% | 4.7% |
| Trend | ↓ | ↑ | ↓ | ↑ | ↑ | ↑ | ↓ |

The Trust YTD absence levels in April 2016 (chart above) were above the 4.4% target at 4.7%.



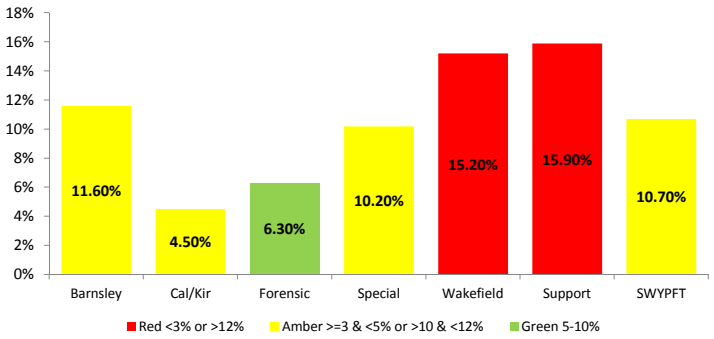

The above chart shows the YTD absence levels in MH/LD Trusts in our region to the end of September 2015. During this time the Trust's absence rate was 4.9% which is below the regional average of 5%.

### Mandatory Training

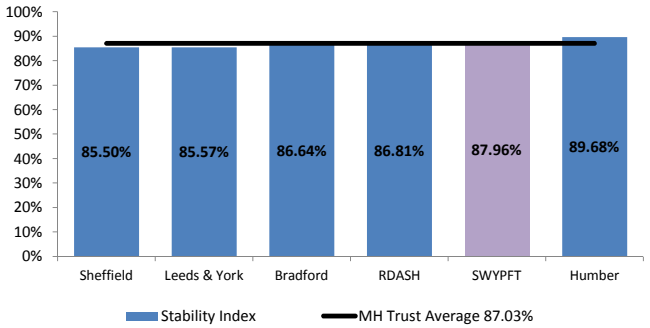



The above chart shows the mandatory training rates for the Trust to the end of May 2016.
Apart from Information Governance (IG), all mandatory training has a target of above 80%; IG has a target of above 95%; all are based on a rolling year.

### Turnover and Stability Rate Benchmark

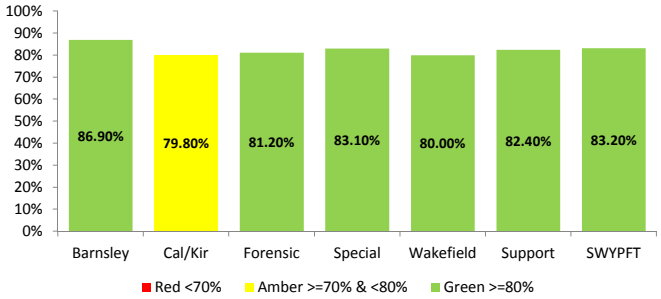



This chart shows the YTD turnover levels up to the end of May 2016.
Turnover figures may look high but this due to the small amount of data, the figures will level out over the new reporting year.




This chart shows stability levels in MH Trusts in the region for the 12 months ending in 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 May 2016.
The Trust continues to achieve its 80% target for fire lecture training, apart from Calderdale & Kirklees BDU which is just below the target.

# Workforce - Performance Wall

## Trust Performance Wall

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.00% | 5.00% | 5.00% | 5.00% | 5.00% | 4.70% |
| Sickness (Monthly) | <=4.4% | 5.30% | 5.00% | 5.40% | 5.10% | 4.80% | 4.70% |
| Appraisals (Band 6 and above) | >=95% | 92.80% | 94.50% | 97.30% | 97.50% | 1.30% | 20.10% |
| Appraisals (Band 5 and below) | >=95% | 83.50% | 89.20% | 96.60% | 96.90% | 0.10% | 6.30% |
| Aggression Management | >=80% | 83.10% | 82.50% | 83.20% | 83.20% | 83.30% | 82.60% |
| Equality and Diversity | >=80% | 90.30% | 90.60% | 91.40% | 92.20% | 91.80% | 92.00% |
| Fire Safety | >=80% | 85.60% | 83.80% | 86.70% | 86.70% | 85.20% | 83.20% |
| Food Safety | >=80% | 75.80% | 75.40% | 77.00% | 78.40% | 78.40% | 79.10% |
| Infection Control and Hand Hygiene | >=80% | 85.80% | 86.50% | 88.20% | 87.60% | 85.60% | 83.40% |
| Information Governance | >=95% | 89.10% | 82.40% | 95.10% | 96.00% | 93.60% | 90.00% |
| Moving and Handling | >=80% | 83.80% | 84.60% | 85.90% | 85.60% | 85.00% | 84.40% |
| Safeguarding Adults | >=80% | 88.30% | 88.70% | 89.40% | 90.20% | 90.30% | 89.00% |
| Safeguarding Children | >=80% | 87.70% | 88.20% | 89.20% | 89.90% | 88.40% | 87.10% |
| Bank Cost | | £414k | £426k | £419k | £548k | £463k | £370k |
| Agency Cost | | £606k | £527k | £774k | £1449k | £805k | £842k |
| Sickness Cost (Monthly) | | £527k | £508k | £571k | £501k | £497k | £470k |
| Vacancies (Non-Medical) (WTE) | | 316.89 | 353.49 | 380.25 | 400.13 | 429.66 | 469.78 |
| Business Miles | | 323k | 327k | 323k | 257k | 345k | 321k |

## Barnsley District

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.30% | 4.40% | 4.50% | 4.60% | 4.60% | 4.20% |
| Sickness (Monthly) | <=4.4% | 5.10% | 5.20% | 5.80% | 5.40% | 4.60% | 4.10% |
| Appraisals (Band 6 and above) | >=95% | 95.60% | 97.20% | 98.20% | 98.60% | 0.00% | 0.00% |
| Appraisals (Band 5 and below) | >=95% | 89.80% | 92.10% | 97.20% | 98.20% | 0.20% | 11.10% |
| Aggression Management | >=80% | 84.10% | 80.80% | 82.60% | 87.00% | 100.00% | 100% |
| Equality and Diversity | >=80% | 92.60% | 93.00% | 93.60% | 94.70% | 100.00% | 100% |
| Fire Safety | >=80% | 86.20% | 85.80% | 89.50% | 89.70% | 100.00% | 100% |
| Infection Control and Hand Hygiene | >=80% | 88.10% | 87.80% | 90.50% | 91.00% | 100.00% | 100% |
| Information Governance | >=95% | 90.50% | 86.40% | 96.20% | 97.40% | 100.00% | 100% |
| Moving and Handling | >=80% | 86.10% | 86.40% | 88.10% | 87.90% | 100.00% | 100% |
| Safeguarding Adults | >=80% | 89.80% | 90.10% | 91.00% | 92.90% | 100.00% | 100% |
| Safeguarding Children | >=80% | 89.00% | 89.40% | 90.40% | 91.70% | 100.00% | 100% |
| Bank Cost | | £65k | £61k | £61k | £50k | £64k | £52k |
| Agency Cost | | £130k | £170k | £168k | £289k | £133k | £207k |
| Sickness Cost (Monthly) | | £176k | £199k | £227k | £196k | £175k | £143k |
| Vacancies (Non-Medical) (WTE) | | 87.34 | 108.19 | 124.09 | 130.8 | 127.33 | 130.14 |
| Business Miles | | 126k | 132k | 135k | 105k | 139k | 127k |

## Calderdale and Kirklees District

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.10% | 5.00% | 5.10% | 5.20% | 5.10% | 4.60% |
| Sickness (Monthly) | <=4.4% | 5.40% | 4.70% | 5.80% | 5.70% | 4.80% | 4.60% |
| Appraisals (Band 6 and above) | >=95% | 99.10% | 99.70% | 100.00% | 100.00% | 3.20% | 22.60% |
| Appraisals (Band 5 and below) | >=95% | 91.70% | 92.50% | 98.40% | 98.40% | 0.00% | 6.40% |
| Aggression Management | >=80% | 86.10% | 87.30% | 87.20% | 85.40% | 85.50% | 85.30% |
| Equality and Diversity | >=80% | 92.00% | 93.20% | 92.40% | 92.80% | 91.90% | 92.10% |
| Fire Safety | >=80% | 85.40% | 83.00% | 86.10% | 86.80% | 85.00% | 79.80% |
| Food Safety | >=80% | 72.00% | 74.50% | 74.10% | 72.10% | 75.90% | 74.70% |
| Infection Control and Hand Hygiene | >=80% | 90.40% | 91.10% | 90.70% | 88.60% | 87.60% | 84.90% |
| Information Governance | >=95% | 87.50% | 83.30% | 96.30% | 96.70% | 95.70% | 91.10% |
| Moving and Handling | >=80% | 83.40% | 84.30% | 85.20% | 84.80% | 84.60% | 83.40% |
| Safeguarding Adults | >=80% | 88.20% | 88.90% | 88.50% | 89.70% | 90.20% | 88.60% |
| Safeguarding Children | >=80% | 89.40% | 91.00% | 90.40% | 90.60% | 89.00% | 87.50% |
| Bank Cost | | £114k | £123k | £147k | £161k | £145k | £102k |
| Agency Cost | | £117k | £124k | £182k | £246k | £232k | £135k |
| Sickness Cost (Monthly) | | £107k | £88k | £124k | £113k | £100k | £107k |
| Vacancies (Non-Medical) (WTE) | | 72.44 | 69.5 | 64.92 | 64.88 | 71.52 | 70.34 |
| Business Miles | | 61k | 63k | 62k | 56k | 66k | 67k |
| | | | | | | | |
| | | | | | | | |

## Forensic Services

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 6.80% | 6.60% | 6.50% | 6.40% | 6.30% | 4.50% |
| Sickness (Monthly) | <=4.4% | 5.70% | 5.00% | 5.10% | 5.60% | 5.40% | 4.50% |
| Appraisals (Band 6 and above) | >=95% | 84.70% | 84.10% | 86.60% | 87.00% | 0.00% | 9.20% |
| Appraisals (Band 5 and below) | >=95% | 77.60% | 83.90% | 89.20% | 89.10% | 0.00% | 2.80% |
| Aggression Management | >=80% | 81.70% | 80.60% | 80.20% | 79.70% | 77.50% | 77.80% |
| Equality and Diversity | >=80% | 92.80% | 93.00% | 92.90% | 93.90% | 93.90% | 93% |
| Fire Safety | >=80% | 89.00% | 83.10% | 86.40% | 85.40% | 79.80% | 81.20% |
| Food Safety | >=80% | 79.70% | 79.60% | 82.70% | 86.00% | 86.80% | 88% |
| Infection Control and Hand Hygiene | >=80% | 85.40% | 87.00% | 88.00% | 88.40% | 87.20% | 83.90% |
| Information Governance | >=95% | 90.80% | 80.60% | 93.00% | 94.30% | 93.50% | 88.90% |
| Moving and Handling | >=80% | 87.90% | 88.80% | 89.20% | 89.20% | 86.70% | 85.40% |
| Safeguarding Adults | >=80% | 91.50% | 91.90% | 92.10% | 92.10% | 90.30% | 85.60% |
| Safeguarding Children | >=80% | 87.70% | 85.20% | 86.10% | 87.30% | 85.40% | 86.40% |
| Bank Cost | | £86k | £108k | £77k | £142k | £123k | £93k |
| Agency Cost | | £68k | £92k | £143k | £320k | £107k | £134k |
| Sickness Cost (Monthly) | | £50k | £41k | £43k | £42k | £45k | £38k |
| Vacancies (Non-Medical) (WTE) | | 37.11 | 45.11 | 49.62 | 49.57 | 51.83 | 53.58 |
| Business Miles | | 12k | 7k | 4k | 6k | 11k | 5k |
| | | | | | | | |
| | | | | | | | |

# Workforce - Performance Wall cont…

## Specialist Services

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 4.80% | 4.80% | 4.80% | 5.00% | 5.00% | 5.70% |
| Sickness (Monthly) | <=4.4% | 3.80% | 4.50% | 5.10% | 6.30% | 5.10% | 5.70% |
| Appraisals (Band 6 and above) | >=95% | 75.10% | 77.90% | 91.80% | 92.30% | 0.50% | 6.90% |
| Appraisals (Band 5 and below) | >=95% | 64.80% | 71.30% | 94.00% | 94.70% | 0.00% | 4.10% |
| Aggression Management | >=80% | 79.80% | 81.20% | 81.60% | 80.00% | 78.20% | 72.30% |
| Equality and Diversity | >=80% | 90.50% | 90.10% | 91.30% | 92.40% | 93.30% | 92.80% |
| Fire Safety | >=80% | 84.60% | 85.10% | 86.00% | 86.80% | 83.90% | 83.10% |
| Food Safety | >=80% | 73.70% | 73.20% | 74.50% | 74.50% | 68.50% | 66.70% |
| Infection Control and Hand Hygiene | >=80% | 85.90% | 86.30% | 87.40% | 87.30% | 85.90% | 83.90% |
| Information Governance | >=95% | 89.50% | 85.20% | 95.90% | 96.40% | 95.00% | 88.30% |
| Moving and Handling | >=80% | 83.10% | 84.80% | 85.70% | 87.00% | 84.90% | 83.60% |
| Safeguarding Adults | >=80% | 84.40% | 84.80% | 86.60% | 86.80% | 86.40% | 86.10% |
| Safeguarding Children | >=80% | 85.60% | 87.70% | 87.80% | 87.30% | 87.30% | 85.90% |
| Bank Cost | | £32k | £25k | £21k | £30k | £18k | £19k |
| Agency Cost | | £146k | £59k | £173k | £313k | £224k | £226k |
| Sickness Cost (Monthly) | | £45k | £45k | £48k | £54k | £49k | £48k |
| Vacancies (Non-Medical) (WTE) | | 40.71 | 39.15 | 49.08 | 55.33 | 55.73 | 70.59 |
| Business Miles | | 40k | 36k | 37k | 28k | 35k | 39k |
| | | | | | | | |
| | | | | | | | |

## Support Services

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.00% | 5.00% | 5.00% | 4.90% | 4.80% | 4.80% |
| Sickness (Monthly) | <=4.4% | 6.00% | 5.40% | 4.90% | 3.70% | 4.10% | 4.80% |
| Appraisals (Band 6 and above) | >=95% | 96.90% | 98.50% | 99.00% | 99.00% | 0.50% | 8.10% |
| Appraisals (Band 5 and below) | >=95% | 74.80% | 89.70% | 99.60% | 99.40% | 0.00% | 2.60% |
| Aggression Management | >=80% | 78.60% | 78.50% | 78.90% | 76.80% | 80.20% | 81.00% |
| Equality and Diversity | >=80% | 80.40% | 80.90% | 84.10% | 84.40% | 84.50% | 85.60% |
| Fire Safety | >=80% | 83.50% | 80.90% | 84.20% | 84.30% | 84.80% | 82.40% |
| Food Safety | >=80% | 89.90% | 87.30% | 91.00% | 90.90% | 87.50% | 91.80% |
| Infection Control and Hand Hygiene | >=80% | 78.30% | 79.20% | 82.00% | 81.20% | 75.30% | 73.80% |
| Information Governance | >=95% | 86.60% | 71.30% | 90.90% | 91.50% | 86.10% | 84.30% |
| Moving and Handling | >=80% | 81.90% | 82.70% | 84.80% | 83.90% | 83.90% | 83.10% |
| Safeguarding Adults | >=80% | 85.40% | 85.90% | 86.90% | 86.90% | 88.40% | 88.40% |
| Safeguarding Children | >=80% | 84.80% | 85.50% | 88.60% | 90.00% | 89.80% | 89.50% |
| Bank Cost | | £39k | £38k | £42k | £57k | £47k | £32k |
| Agency Cost | | £74k | £33k | £42k | £135k | £51k | £36k |
| Sickness Cost (Monthly) | | £84k | £81k | £73k | £50k | £61k | £66k |
| Vacancies (Non-Medical) (WTE) | | 37.2 | 43.98 | 41.82 | 45.57 | 70.28 | 73.94 |
| Business Miles | | 48k | 45k | 42k | 32k | 54k | 45k |
| | | | | | | | |
| | | | | | | | |

## Wakefield District

| Month | | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|---|---|---|
| Sickness (YTD) | <=4.4% | 5.50% | 5.40% | 5.30% | 5.30% | 5.30% | 5.90% |
| Sickness (Monthly) | <=4.4% | 5.80% | 4.80% | 5.00% | 4.10% | 5.40% | 5.90% |
| Appraisals (Band 6 and above) | >=95% | 91.80% | 95.10% | 97.90% | 97.90% | 1.10% | 17.70% |
| Appraisals (Band 5 and below) | >=95% | 81.30% | 87.00% | 93.90% | 93.90% | 0.00% | 1.30% |
| Aggression Management | >=80% | 84.20% | 82.10% | 83.80% | 85.20% | 86.10% | 86.40% |
| Equality and Diversity | >=80% | 92.60% | 91.50% | 92.70% | 93.50% | 94.00% | 94.80% |
| Fire Safety | >=80% | 85.20% | 82.50% | 82.90% | 81.10% | 77.50% | 80.00% |
| Food Safety | >=80% | 69.50% | 68.80% | 70.40% | 72.30% | 70.00% | 73.10% |
| Infection Control and Hand Hygiene | >=80% | 82.00% | 85.30% | 86.70% | 84.10% | 80.80% | 76.80% |
| Information Governance | >=95% | 89.00% | 84.40% | 97.00% | 97.90% | 96.80% | 93.80% |
| Moving and Handling | >=80% | 77.60% | 78.30% | 79.00% | 78.60% | 76.90% | 76.00% |
| Safeguarding Adults | >=80% | 89.00% | 88.20% | 89.70% | 88.80% | 90.00% | 87.70% |
| Safeguarding Children | >=80% | 86.30% | 86.40% | 87.70% | 87.20% | 85.70% | 85.20% |
| Bank Cost | | £78k | £72k | £71k | £108k | £66k | £71k |
| Agency Cost | | £71k | £49k | £66k | £145k | £58k | £102k |
| Sickness Cost (Monthly) | | £64k | £55k | £56k | £45k | £67k | £68k |
| Vacancies (Non-Medical) (WTE) | | 40.49 | 45.96 | 48.79 | 51.83 | 58.63 | 75.79 |
| Business Miles | | 37k | 44k | 43k | 31k | 40k | 36k |
| | | | | | | | |
| | | | | | | | |

# Publication Summary

**Care Quality Commission (CQC)**

Better care in my hands: a review of how people are involved in their care

This report describes how well people are involved in their own care and what good involvement looks like. It is based on newly analysed evidence from our national reports and inspection findings, as well as national patient surveys and a literature review. It identifies what enables people and their families to work in partnership with health and social care staff and illustrates this with good practice examples from our inspection findings.
Click here for briefing

**Department of Health (DH)**

Improving the physical health of people with mental health problems: actions for mental health nurses

This evidence-based information will help mental health nurses to improve the physical health and wellbeing of people living with mental health problems. This document focuses on how to deal with some of the main risk factors for physical health problems, and helps to make sure that people living with mental health problems have the same access to health checks and healthcare as the rest of the population.
Click here for guidance

**Care Quality Commission (CQC)**

Shaping the future: CQC's strategy for 2016 to 2021

This five-year strategy sets out CQC's vision and ambitions for a more targeted, responsive and collaborative approach to regulation so that more people receive high-quality care. It describes how CQC will combine learning from 22,000 comprehensive inspections with better use of intelligence from the public, providers and partners in order to focus inspections more tightly to where people may be at risk of poor care. The new strategy also aims to encourage services to innovate and collaborate to drive improvement.
Click here for strategy

**Children's Commissioner**

Lightning review: access to child and adolescent mental health services, May 2016

This review of access to mental health services highlights the long waiting lists and restricted access for those with life-threatening conditions. From a request for data from public bodies, the review found that 28 per cent of children who were referred for specialist mental health treatment in 2015 did not receive a service. A significant proportion of children with life-threatening mental health conditions - 14 per cent of the 3,000 about whom information was obtained - were denied specialist support. These included children who had attempted suicide or serious self-harm and those with psychosis and anorexia nervosa.

Click here for report

# Publication Summary cont…

**Care Quality Commission (CQC)**

Consultation on changes to the NHS patient survey programme

The survey programme is used to collect feedback on the experiences of people using a range of NHS healthcare services. The current programme includes surveys of adult inpatients, community mental health service users, people using maternity services, outpatients, children and young people's inpatient services and accident and emergency patients. Our aim in consulting on changes is to ensure that the programme has maximum impact and value, and that it remains relevant and useful for those using the survey results across the health and social care system. The consultation will run to 21 July 2016.
Click here for consultation

**Care Quality Commission (CQC)**

2015 adult inpatient survey

This survey provides information on the experiences of people admitted to an acute or acute specialist NHS hospital in England in 2015. The results indicate that there have been small, but statistically significant improvements in a number of areas, compared with previous surveys. This includes patients' perceptions of the quality of communication between medical professionals and patients, the standards of hospital cleanliness, the availability of help to eat when needed, the number of nurses on duty and being involved in decisions about their care and treatment.
Click here for report

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

How is the NHS performing? Quarterly monitoring report (The Kings Fund)
Child measurement programme: academic year ending July 2015
Direct access audiology waiting times for March 2016
Bed availability and occupancy: quarter ending March 2016
Mixed sex accommodation breaches, April 2016
NHS outcome framework indicators - May 2016 release
Learning disability services monthly statistics - England commissioner census (Assuring Transformation) - April 2016, experimental statistics
Improving Access to Psychological Therapies report, February 2016 final, March 2016 primary and most recent quarterly data (quarter 3 2015/16)
Mental health services monthly statistics: final February, provisional March 2016
NHS workforce statistics - February 2016, provisional statistics
NHS sickness absence rates: January 2016
Provisional monthly hospital episode statistics for admitted patient care, outpatients and accident and emergency data - April 2015 to March 2016
NHS Improvement provider bulletin: 25 May 2016
Learning disability statistics - annual overview, England 2015-2016
Referral to treatment waiting times statistics for consultant-led elective care annual report, 2015/16
Monthly hospital activity data, April 2016
Early intervention in psychosis access and waiting time experimental statistics, April 2016
Diagnostics waiting times and activity, April 2016
Delayed transfers of care, April 2016
Combined performance summary, April 2016

# Glossary

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

| KEY for dashboard Year End Forecast Position | |
|---|---|
| 4 | Forecast met, no plan required/plan in place likely to deliver |
| 3 | Forecast risk not met, plan in place but unlikely to deliver |
| 2 | Forecast high risk not met, plan in place but vey unlikely to deliver |
| 1 | Forecast Not met, no plan / plan will not deliver |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 28 June 2016
# Agenda item 6.2

| | |
|---|---|
| **Title:** | **Finance Report month 2 2016/17** |
| **Paper prepared by:** | Director of Finance |
| **Purpose:** | To inform Trust Board of the financial position of the Trust as at month 2 2016/17.<br>To raise any specific financial risks and issues with Trust Board and enable a discussion to take place regarding any actions that need to be taken to address these risks and issues. |
| **Mission/values/objectives:** | To improve use of resources |
| **Any background papers/ previously considered by:** | Not applicable |
| **Executive summary:** | • In-month surplus of £0.5 million and year-to-date surplus of £0.6 million. Cumulative position is £0.1 million ahead of plan<br>• Full year forecast remains at a surplus of £1.85 million. This is £1.35 million higher than Board approved financial plan due to NHS Improvement making additional funding available from the Sustainability and Transformation Fund.<br>• Financial risk rating of 4.<br>• Cash balance of £25.6 million, which is £2.4 million below plan largely due to timing of creditor payments<br>• CIP achievement of £1.3 million year-to-date, which is £0.5 million below plan. Full year cost improvement programme risk of £2.9 million with focus being applied to how this can be achieved or where replacement schemes can be identified.<br>• £0.8 million of Contracting for Quality and Innovation (CQUIN) income currently considered as a risk. Consideration being given to how this risk can be reduced.<br>• Agency staff expenditure is above NHS Improvement target. Additional controls and monitoring processes being developed.<br>• Capital expenditure currently behind plan, but forecast remains in line with full year plan |
| **Recommendation:** | **Trust Board is asked to REVIEW the finance report and discuss any specific issues arising from it.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Finance Report

## Month 2 (2016/2017)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

# Contents

## 1.0 Executive Summary / Key Performance Indicators

| | Performance Indicator | Year to Date | Forecast | Narrative |
|---|---|---|---|---|
| 1 | NHS Improvement Risk Rating | 4 | 4 | The Trust has planned for and delivered, a risk rating of 4 in May 2016. It is currently forecast that a rating of 4 will be maintained throughout the year. |
| 2 | Surplus | £0.59m | £1.85m | The year to date position shows a surplus of £589k; this is £145k better than planned. Full year forecast remains in line with plan at £1.85m. This will require use of all contingency, based on current BDU projections and risk associated with CIP delivery which must be mitigated. |
| 3 | Agency Cap | £1.65m | tbc | NHS Trusts have been set maximum agency spend caps for 2016 / 2017 by NHS Improvement. Expenditure in month 2 is in line with month 1 and based on this tread this cap will be breached. Additional control and monitoring are to be put in place. A full understanding of the current baseline is taking place including the impact of 'specialling' and acuity. |
| 4 | Cash | £25.6m | £23.2m | The cash position is lower than planned at May 2016 mainly due to creditor payments. The forecast position projects the Trust to be back in line with plan from month 3. |
| 5 | Capital | £1.15m | £12.31m | Capital expenditure is marginally under plan as at May 2016. This is due to timing delays in major schemes but these remain forecast to deliver on time and in budget. |
| 6 | Delivery of CIP | £1.32m | £7.17m | Year to date CIP delivery is £0.52m behind plan . Overall the forecast position includes £2.89m of red rated schemes, against which actions must be taken or replacements identified to ensure delivery. |
| 7 | Better Payment | 98% | | This performance is based upon a combined NHS / Non NHS value. We do not currently forecast future performance against this KPI. |

| | |
|---|---|
| Red | Variance from plan greater than 15% |
| Amber | Variance from plan ranging from 5% to 15% |
| Green | In line, or greater than plan |

# 1.1 NHS Improvement Risk Rating

The Trust currently completes a detailed return demonstrating current and financial performance to NHS Improvement on a monthly basis. This is summarised, as per the Risk Assessment Framework, into a Financial Risk Rating and scored on a range of 0 to 4 (with 4 being the best rating possible.)

As highlighted below current performance is better than planned for all metrics. The detailed financial modelling and forecast also illustrate that the Trust will achieve a rating of 4 for the remainder of the year. Successful achievement of this rating is dependant upon delivery of the overall financial plan and therefore mitigation of current risks identified.

| | | | | Actual Performance | | Plan - Month 2 | |
|---|---|---|---|---|---|---|---|
| | Financial Criteria | Weight | Metric | Score | Risk Rating | Score | Risk Rating |
| Continuity of Services | Balance Sheet Sustainability | 25% | Capital Service Capacity | 5.2 | 4 | 3.6 | 4 |
| | Liquidity | 25% | Liquidity (Days) | 17.4 | 4 | 14.5 | 4 |
| Financial Efficiency | Underlying Performance | 25% | I & E Margin | 1.4% | 4 | 1.2% | 4 |
| | Variance from Plan | 25% | Variance in I & E Margin as a % of income | 0.2% | 4 | -0.4% | 3 |
| | **Weighted Average - Financial Sustainability Risk Rating** | | | | 4 | | 4 |

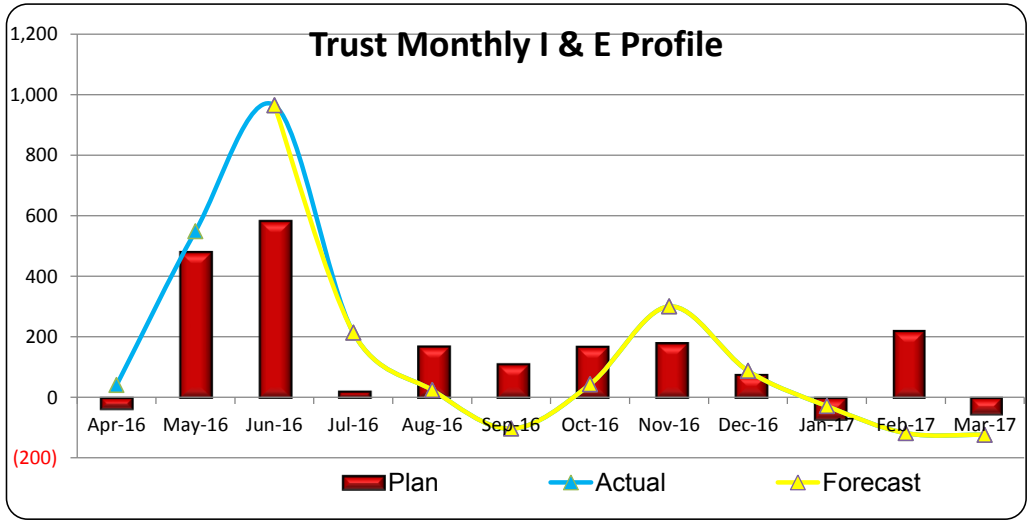
**Definitions**

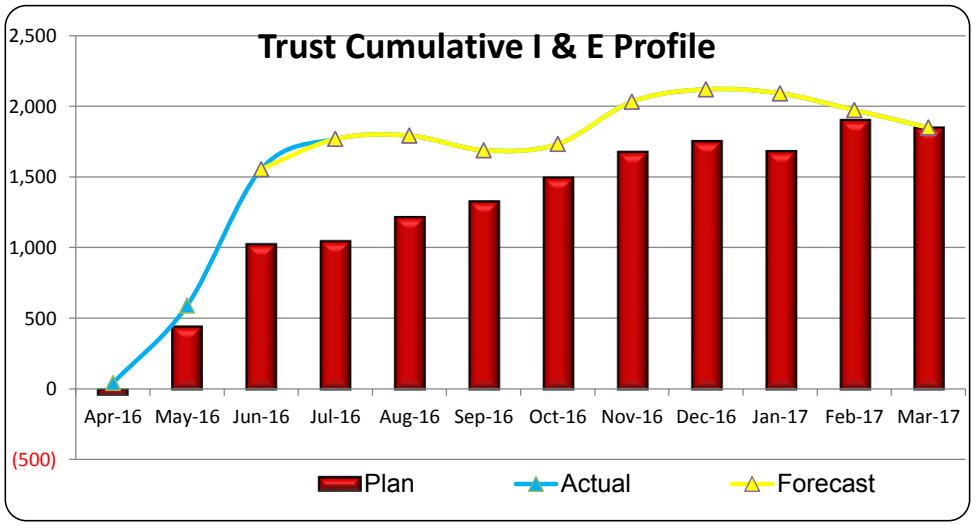
**Capital Servicing Capacity** - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.
**Liquidity** - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.
**I & E Margin** - the degree to which the organisation is operating at a surplus / deficit
**I & E Variance** - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

**Risk Rating 4** - No evident Concerns
**Risk Rating 3** - Emerging or minor concern potentially requiring scrutiny.

# 2.0 Income & Expenditure Position 2016 / 2017

| Budget Staff in Post | Actual Staff in Post | Variance | | This Month Budget | This Month Actual | This Month Variance | Description | Year to Date Budget | Year to Date Actual | Year to Date Variance | Annual Budget | Forecast Outturn | Forecast Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **WTE** | **WTE** | **WTE** | **%** | **£k** | **£k** | **£k** | | **£k** | **£k** | **£k** | **£k** | **£k** | **£k** |
| | | | | | | | | | | | | | |
| | | | | 17,871 | 17,870 | (1) | Clinical Revenue | 35,757 | 35,836 | 78 | 210,452 | 210,452 | 0 |
| | | | | **17,871** | **17,870** | **(1)** | **Total Clinical Revenue** | **35,757** | **35,836** | **78** | **210,452** | **210,452** | **0** |
| | | | | 1,350 | 1,299 | (51) | Other Operating Revenue | 2,641 | 2,449 | (192) | 14,820 | 14,875 | 55 |
| | | | | **19,221** | **19,169** | **(51)** | **Total Revenue** | **38,398** | **38,284** | **(114)** | **225,273** | **225,328** | **55** |
| | | | | | | | | | | | | | |
| 4,499 | 4,115 | (384) | 8.5% | (14,950) | (14,460) | 490 | BDU Expenditure - Pay | (29,684) | (29,019) | 665 | (171,580) | (172,003) | (424) |
| | | | | (3,687) | (3,800) | (113) | BDU Expenditure - Non Pay | (7,445) | (7,260) | 186 | (43,475) | (45,304) | (1,829) |
| | | | | 708 | 702 | (6) | Provisions | 694 | 709 | 16 | 816 | 3,090 | 2,274 |
| **4,499** | **4,115** | **(384)** | **8.5%** | **(17,929)** | **(17,557)** | **371** | **Total Operating Expenses** | **(36,435)** | **(35,569)** | **867** | **(214,238)** | **(214,216)** | **22** |
| | | | | | | | | | | | | | |
| **4,499** | **4,115** | **(384)** | **8.5%** | **1,292** | **1,612** | **320** | **EBITDA** | **1,963** | **2,716** | **753** | **11,035** | **11,111** | **77** |
| | | | | (562) | (813) | (252) | Depreciation | (1,018) | (1,627) | (609) | (6,180) | (6,257) | (77) |
| | | | | (257) | (257) | 0 | PDC Paid | (513) | (513) | 0 | (3,080) | (3,080) | 0 |
| | | | | 6 | 7 | 1 | Interest Received | 13 | 14 | 1 | 75 | 75 | 0 |
| | | | | 0 | 0 | 0 | Revaluation of Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| **4,499** | **4,115** | **(384)** | **8.5%** | **480** | **549** | **69** | **Surplus / (Deficit)** | **444** | **589** | **145** | **1,850** | **1,850** | **(0)** |



# Income & Expenditure Position 2016 / 2017

**Trust Annual Plan**

As agreed at Trust Board the Trust submitted, in April 2016, an Annual Plan which had as its baseline position a surplus of £500k. This was lower than the control total for 16/17 originally requested by Monitor.

Additional discussions have been held with NHS Improvement and following new allocations from the Sustainability and Transformation Fund (STP) a revised control total has been set and agreed as £1.85m surplus. This has been included presentationally within this report and a revised Annual Plan submission will be required. It is assumed that this additional funding will be cash backed and further guidance for receipt will be issued by NHS Improvement.

**Month 2**

For the year to date the Trust has delivered a surplus position of £589k, this is £145k better than plan. This is an increase in surplus of £69k in month.

In month healthcare income (arising from our agreed contract with Commissioners and additional beds provided to Out of Area Commissioners) is in line with plan. Other income recharged by BDUs is under recovering and this is largely due to a recharge of costs being less than planned and are offset by a corresponding variance in non pay.

Operating Expenditure is lower than plan; by £867k year to date and £371k in month.

Of this expenditure on pay accounts for £665k underspend (£490k in month). This is after taking into account the increased level of agency expenditure being experienced. This trend is across the vast majority of our BDUs. Most significant savings are in support services (£335k ytd), whilst there is also a saving in LD & Specialist. Both Wakefield and Calderdale & Kirklees BDU's are currently operating with small overspends.

Non Pay expenditure has overspent by £113k in month. The most significant variance relates to providing suitable Out of Area placements. Work continues to reduce this type of expenditure.

Other expenditure is in line with plan with the exception of deprecation charges. This is partially due to the profile of the submitted plan (which was in 12ths) when compared to the profile of actual depreciation charges. These charges are higher at the start of the year due to the accelerated depreciation impact arising from the Fieldhead Non Secure Capital programme. We will look to revise the plan profile as part of any revised Annual Plan submission.

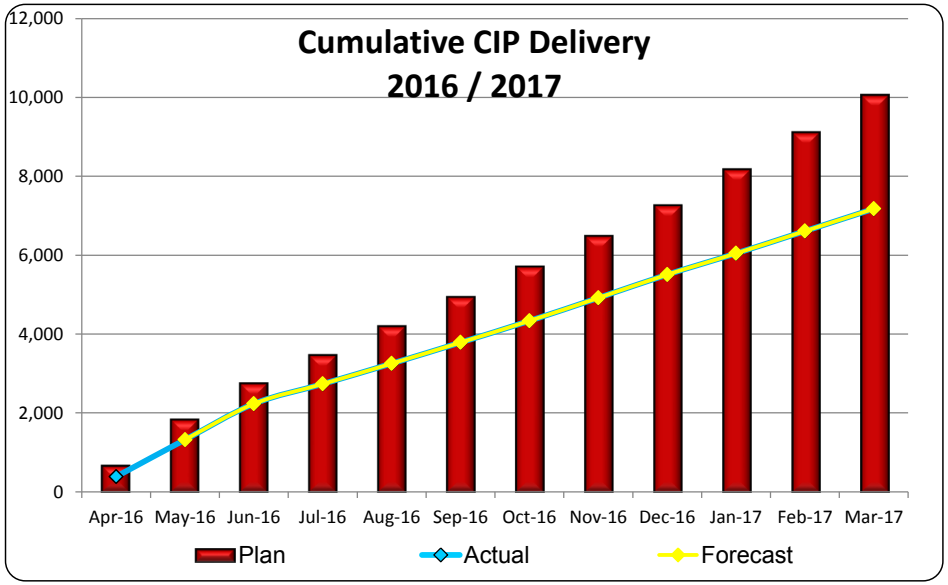
**Forecast**

The forecast outturn position for 2016 / 2017 is a surplus position of £1.85m which is in line with plan.

When all BDU projections are added together this provides a current risk to achieving the plan. The Trust is still striving to achieve £1.85m. Required measures to achieve this will be assessed. Contingency usage of c. £2.2m is being assumed in the current forecast and the risk around CIP delivery continues to be assessed. Additionally a £0.8m risk against CQUIN income has been identified which is being managed in more

# 2.1 Cost Improvement Programme 2016 / 2017

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k |
| Target - Recurrent | 661 | 662 | 662 | 665 | 679 | 695 | 717 | 723 | 728 | 863 | 891 | 891 | 1,323 | 8,837 |
| Target - Non Recurrent | 9 | 509 | 259 | 49 | 49 | 49 | 49 | 49 | 49 | 49 | 49 | 49 | 519 | 1,223 |
| Target - Monitor Submission | 670 | 1,172 | 922 | 715 | 729 | 744 | 766 | 772 | 777 | 912 | 940 | 940 | 1,842 | 10,059 |
| Target - Cumulative | 670 | 1,842 | 2,764 | 3,479 | 4,207 | 4,952 | 5,718 | 6,490 | 7,267 | 8,179 | 9,119 | 10,059 | 1,842 | 10,059 |
| | | | | | | | | | | | | | | |
| Delivery as planned | 381 | 1,305 | 1,909 | 2,307 | 2,718 | 3,146 | 3,589 | 4,065 | 4,549 | 5,081 | 5,641 | 6,200 | 1,305 | 6,200 |
| Mitigations - Recurrent | 0 | 6 | 9 | 12 | 15 | 18 | 21 | 24 | 27 | 30 | 34 | 37 | 6 | 37 |
| Mitigations - Non Recurrent | 1 | 8 | 311 | 414 | 517 | 620 | 723 | 826 | 929 | 932 | 935 | 938 | 8 | 938 |
| Total Delivery | **382** | **1,319** | **2,230** | **2,733** | **3,251** | **3,784** | **4,333** | **4,915** | **5,506** | **6,043** | **6,609** | **7,175** | **1,319** | **7,175** |
| | | | | | | | | | | | | | | |
| Shortfall / Unidentified | 289 | 523 | 534 | 746 | 957 | 1,168 | 1,385 | 1,575 | 1,761 | 2,136 | 2,510 | 2,885 | 523 | 2,885 |




The Trust identified a CIP programme for 2016 / 2017 which totalled £10.06m. This was subject to an external review.

By May 2016 £6.20m of the original programme is forecast to deliver as planned (62%). This currently leaves £2.89 identified as red rated and in need of action to ensure delivery during 2016 / 2017.

The main risk relates to the following schemes which have amber and red ratings:

| | **£k** | Note |
|---|---|---|
| Management & Admin Review | 1,181 | 1 |
| Non Healthcare SLA's | 800 | |
| Out of Area Expenditure | 500 | |
| Psychology Review | 220 | |
| Total | **2,701** | |

Note 1 - expected to be covered non-recurrently

Work continues to progress these schemes including identifying mitigations where appropriate. This includes greater management focus on a weekly basis and BDU reviews with the Director of Finance. This particularly applies to red and amber schemes.

# 3.0 Balance Sheet 2016 / 2017

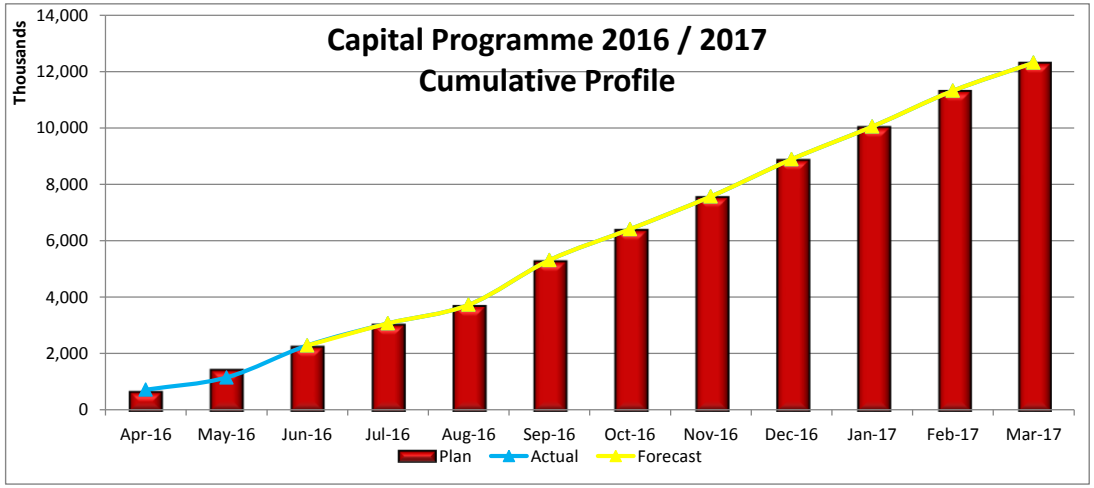
| | 2015 / 2016 £k | Plan (YTD) £k | Actual (YTD) £k | Note |
|---|---|---|---|---|
| Non-Current (Fixed) Assets | 114,134 | 114,684 | 113,926 | 1 |
| **Current Assets** | | | | |
| Inventories & Work in Progress | 190 | 190 | 190 | |
| NHS Trade Receivables (Debtors) | 2,623 | 3,123 | 1,509 | 2 |
| Other Receivables (Debtors) | 7,541 | 7,141 | 7,796 | 3 |
| Cash and Cash Equivalents | 27,107 | 27,958 | 25,566 | 4 |
| **Total Current Assets** | **37,461** | **38,411** | **35,060** | |
| **Current Liabilities** | | | | |
| Trade Payables (Creditors) | (6,430) | (6,430) | (3,898) | 5 |
| Other Payables (Creditors) | (3,481) | (3,994) | (3,817) | 5 |
| Capital Payables (Creditors) | (785) | (785) | (698) | |
| Accruals | (8,576) | (10,326) | (8,116) | 6 |
| Deferred Income | (789) | (789) | (773) | |
| **Total Current Liabilities** | **(20,060)** | **(22,324)** | **(17,302)** | |
| **Net Current Assets/Liabilities** | **17,401** | **16,088** | **17,758** | |
| **Total Assets less Current Liabilities** | **131,535** | **130,772** | **131,684** | |
| Provisions for Liabilities | (10,017) | (8,810) | (9,577) | |
| **Total Net Assets/(Liabilities)** | **121,518** | **121,962** | **122,108** | |
| Taxpayers' Equity | | | | |
| Public Dividend Capital | 43,492 | 43,492 | 43,492 | |
| Revaluation Reserve | 19,446 | 19,446 | 19,446 | |
| Other Reserves | 5,220 | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 53,361 | 53,805 | 53,950 | 7 |
| **Total Taxpayers' Equity** | **121,518** | **121,962** | **122,108** | |

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

1. The capital programme is currently behind profile but this is forecast to move back in line with plan over the next couple of months.
2. NHS Debtors are lower than planned as timing problems experienced in previous years (and factored into the plan) have not occurred. This continues to be managed and focus remains on the £139k older than 91 days.
3. Other debtors are higher than plan primarily due to outstanding payments for block agreements with Local Authorities. In most cases Purchase Orders have now been provided and payment is expected in June 2016.
4. The reconciliation of Actual Cash Flow to Plan compares the current month end position to the Annual Plan position for the same period. This is on page 12.
5. Creditors remain lower than planned. The Trust continue to proactively pay invoices once appropriate approval has been secured. This decision continues to be assessed against the Trust cash position.
6. Overall accruals are lower than planned.
7. This reserve represents year to date surplus plus reserves brought forward.

# 3.1 Capital Programme 2016 / 2017

| | Annual Budget £k | Year to Date Plan £k | Year to Date Actual £k | Year to Date Variance £k | Forecast Actual £k | Forecast Variance £k | Note |
|---|---|---|---|---|---|---|---|
| **Maintenance (Minor) Capital** | | | | | | | |
| Facilities & Small Schemes | 2,050 | 94 | 119 | 25 | 2,050 | 0 | |
| IM&T | 1,210 | 68 | 31 | (37) | 1,210 | 0 | |
| **Total Minor Capital & IM &T** | **3,260** | **162** | **150** | **(12)** | **3,260** | **0** | |
| **Major Capital Schemes** | | | | | | | |
| Pontefract Hub | 1,795 | 687 | 565 | (122) | 1,795 | 0 | 3 |
| Wakefield Hub | 735 | 375 | 375 | 0 | 735 | 0 | |
| Fieldhead Non Secure | 4,725 | 19 | 12 | (7) | 4,725 | 0 | |
| Fieldhead Development | 1,300 | 0 | 2 | 2 | 1,300 | 0 | |
| Other | 498 | 220 | 172 | (48) | 498 | 0 | 4 |
| **Total Major Schemes** | **9,053** | **1,301** | **1,126** | **(176)** | **9,053** | **0** | |
| VAT Refunds | 0 | 0 | (128) | (128) | 0 | 0 | 2 |
| **TOTALS** | **12,313** | **1,463** | **1,147** | **(316)** | **12,313** | **0** | |

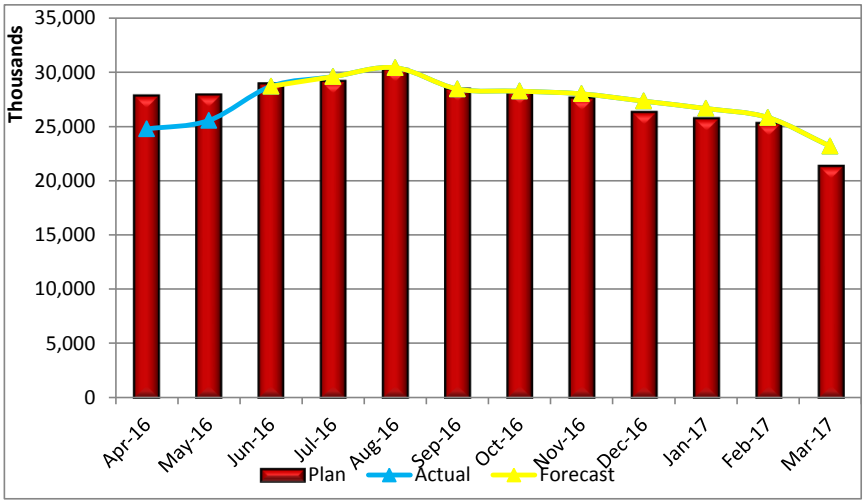



**Capital Expenditure 2016 / 2017**

1. The Trust Capital Programme for 2016 / 2017 is £12.3m and schemes are guided by the Trust Estates Strategy.
2. The year to date position is £0.32m behind plan (22%). Of this £128k relates to VAT recovery following a successful VAT recovery exercise and has been agreed with HMRC. This is reflected to ensure full transparency of costs associated with the Trust Capital Programme.
3. Pontefract Hub has a slightly changed spend profile due to issues encountered with the existing Baghill House property which forms part of the hub. The issues have been resolved and the scheme remains forecast to deliver on time and within agreed budgets.
4. The Bretton scheme is slightly behind spend profile but the scheme remains due to complete in July 2016 as planned. As such it is forecast that spend will return in line with plan over the next 2 months.

   Overall the forecast position assumes that all spend will be back in line with plan from month 3 and work continues to validate any risk within this assumption. At this stage no significant risks are flagged around delivery of this capital programme during 2016 / 2017.

# 3.2 Cash Flow & Cash Flow Forecast 2016 / 2017




| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 27,107 | 27,107 | |
| Closing Balance | 27,958 | 25,566 | (2,392) |

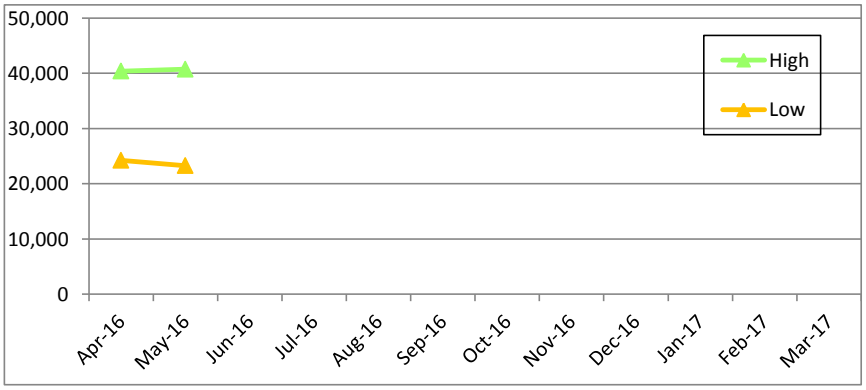
The Cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

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

Overall the cash position is £25.57m which is £2.39m lower than planned.

A detailed reconciliation of working capital compared to plan is presented at page 11.

During April 2016 the Trust have again invested with the National Loan Fund (NLF). This secures a higher rate than the main Government Banking Service.
(0.43% compared to 0.25%)



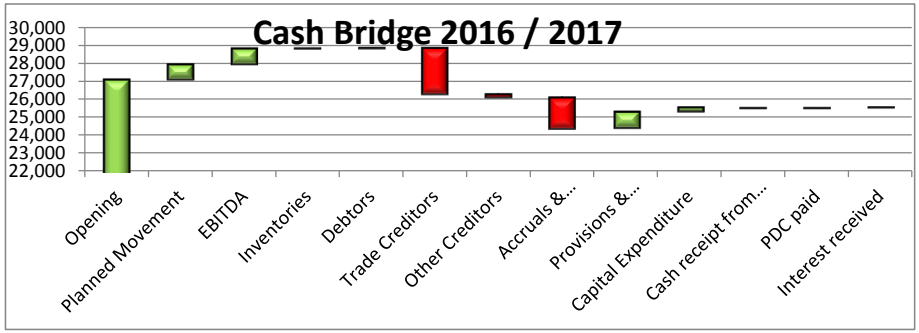

The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

| | |
|---|---|
| The highest balance | £40.76m |
| The lowest balane is: | £23.27m |

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

# 3.3 Reconciliation of Cashflow to Cashflow Plan

| | Plan £k | Actual £k | Variance £k | Note |
|---|---|---|---|---|
| **Opening Balances** | **27,107** | **27,107** | | |
| Surplus (Exc. non-cash items & revaluation) | 1,857 | 2,743 | 886 | 1 |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | 0 | 0 | |
| Receivables (Debtors) | 775 | 792 | 17 | |
| Trade Payables (Creditors) | 0 | (2,532) | (2,532) | 4 |
| Other Payables (Creditors) | 0 | (177) | (177) | |
| Accruals & Deferred income | 1,250 | (476) | (1,726) | 5 |
| Provisions & Liabilities | (1,582) | (672) | 910 | 2 |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (1,463) | (1,234) | 229 | 3 |
| Cash receipts from asset sales | 0 | 0 | 0 | |
| PDC Dividends paid | 0 | 0 | 0 | |
| Interest (paid)/ received | 13 | 14 | 1 | |
| **Closing Balances** | **27,958** | **25,566** | **(2,392)** | |




The Plan value reflects the April 2016 submission to Monitor.

Factors which increase the cash positon against plan:

1. The surplus position at month 2 is higher than plan. This includes the non cash impact of depreciation (which is also higher than planned).
2. Provisions remain unspent on the Balance Sheet resulting in a cash benefit to the current position. Prepayment of invoices also remain lower than planned.
3. In line with the capital programme being behind plan, and secured VAT recovery giving a subsequent cash benefit, this has an overall positive impact on the Trust cash position.

Factors which decrease the cash position against plan:

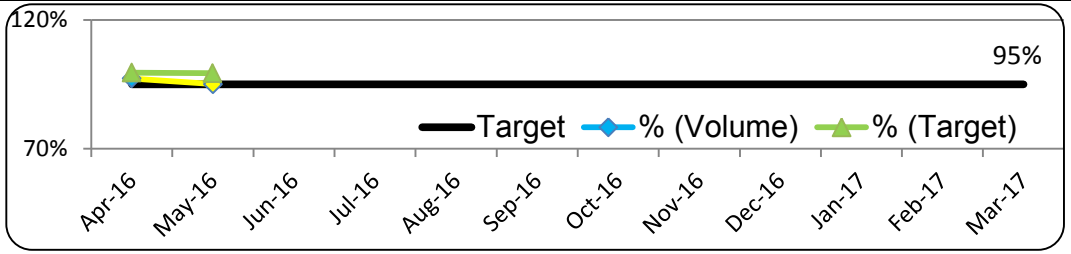
4. Overall creditors remain lower than planned. We have continued to ensure that all approved invoices are paid as soon as possible prior to the Trust planned upgrade of it's financial ledger system in June 2016.
5. Overall accruals, and assumptions around expenditure commitments remain lower than planned.

The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

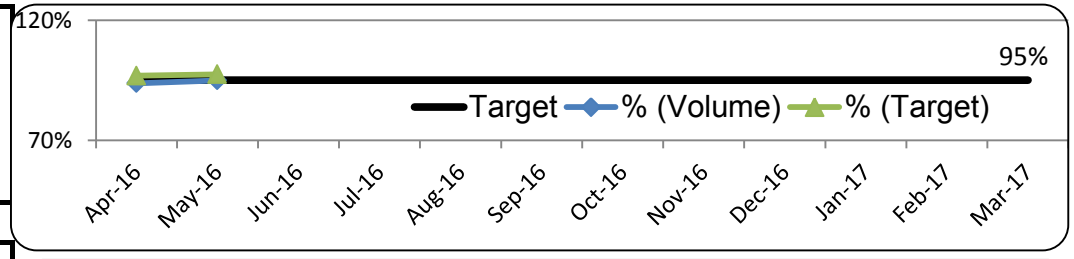
# 4.0 Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code , payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process.

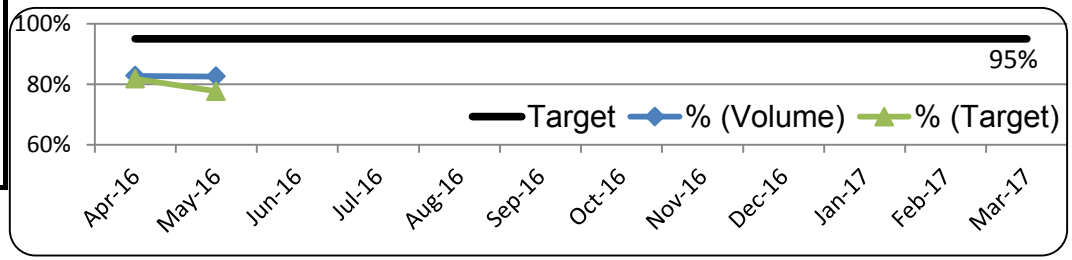
| NHS | Number % | Value % |
|---|---|---|
| Year to April 2016 | 97% | 100% |
| Year to May 2016 | 95% | 99% |




| Non NHS | Number % | Value % |
|---|---|---|
| Year to April 2016 | 94% | 97% |
| Year to May 2016 | 95% | 98% |




| Local Suppliers (10 days) | Number % | Value % |
|---|---|---|
| Year to April 2016 | 83% | 82% |
| Year to May 2016 | 83% | 78% |



# 4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, by public sector bodies expenditure over £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence.

At the current time Monitor has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.
The transparency information for the current month is shown in the table below.

| Date | Expense Type | Expense Area | Supplier | Transaction Number | Amount (£) |
|---|---|---|---|---|---|
| 13/05/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2201737 | 44,932 |
| 18/04/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2200460 | 44,712 |
| 18/04/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2200460 | 42,907 |
| 05/05/2016 | Specialty Registrar (CT1-3) | Trustwide | Leeds and York Partnership NHS FT | 2201199 | 42,043 |
| 13/05/2016 | Drugs | Trustwide | Lloyds Pharmacy Ltd | 2201737 | 40,877 |
| 17/05/2016 | CNST contributions | Trustwide | NHS Litigation Authority | 8156630 | 33,986 |

# 4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect
* Non-Recurrent - an action or decision that has a one off or time limited effect
* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.
* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year
* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.
* Forecast Surplus - This is the surplus we expect to make for the financial year
* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions) and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2016 / 2017 the Trust were set a control total surplus.
* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.
* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.
* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.
* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.
* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

# Trust Board 28 June 2016
# Agenda item 6.3(i)

| | |
|---|---|
| **Title:** | **Transformation programme update** |
| **Paper prepared by:** | Interim Director of Strategic Planning and Contracting |
| **Purpose:** | The purpose of this report is to provide assurance to Trust Board on the delivery of the Transformation Programme.<br>Trust Board is asked to note the progress and the next steps in each project.<br>There are no new risks arising from this programme which currently require escalation to Trust Board. |
| **Mission/values:** | The Transformation Programme is one way in which we ensure that we improve and aim to be outstanding so that our services are ready for tomorrow. In delivering the Transformation Programme it is essential that we keep our focus on putting people first and in the centre.<br>At the present time several of the transformation projects are at the stage of consulting with colleagues about new roles and ways of working. This reminds us of the importance of our value to be respectful, honest, open and transparent |
| **Any background papers/ previously considered by:** | Trust Board receives quarterly updates regarding the delivery of the Transformation Programme. The most recent updates prior to this one was received by Trust Board in March 2016 |
| **Executive summary:** | • The Transformation Programme is structured in three Trust-wide work streams (General Community, Learning Disabilities and Mental Health) each led by a Lead Director, and each having clinical leadership in place.<br>• Several of the projects within the current portfolio of changes in scope are now nearing a key transition point between implementation of changes to services and the realisation of benefits arising from those changes.<br>• Projects at or close to this stage of development include the Acute and Community Mental Health project (the largest one), and the Learning Disabilities project. In both cases provision is now being made for the tracking of benefits realisation, and ongoing oversight of clinical and operational matters identified through the Quality Impact Assessment process.<br>• The approach taken in some of the projects is being adapted in response to changing external circumstances. These include the mental health rehabilitation and recovery project, where a new model of care is now in place in some districts, but further partnership work is required in others to achieve the same goal.<br>• The General Community work stream illustrates a need within this programme and more widely for the Trust to keep the portfolio of changes within the Transformation Programme under review. In response to the future possibilities created through the application of ideas such as multi-specialty community provider and accountable care |

| | |
|---|---|
| | systems, this work stream has adapted to reflect changing priorities.<br>Work is underway to ensure that the whole portfolio is current and aligned to strategic objectives and priorities. Additional work is ensuring that the governance arrangements for the transformation programme are fully effective. |
| **Recommendation:** | **Trust Board is asked to NOTE the progress and the next steps in each project.** |
| **Private session:** | Not applicable |

#

South West Yorkshire Partnership NHS
NHS Foundation Trust

**Trust Board 28 June 2016**

# Transformation Update

With **all of us** in mind.

#

# 1. Acute and Community Mental Health

**1.1 The purpose of this project is to:**

- Ensure care is delivered in the least restrictive and most empowering way possible, with more people being supported at home.
- Reduce the need for admission to hospital or the need for Intensive Home Based Treatment as an alternative to admission.
- Minimise the potential of people being subjected to multiple assessments at service interfaces and reduce the number of hand overs of care between teams.
- Provide effective, evidence-based treatments to reduce and shorten distress and disability.
- Promote recovery based approaches.
- Support people to stay well in primary care through collaborative working and shared care arrangements.
- The move to the new operational model will achieve an annualised cost saving of £900,894, of which £200,623 has already been realised.

**1.2 Staff Consultation Process**

- The acute and community mental health transformation project has recently completed formal consultation with over 500 staff affected by the planned changes.
- Staff from all professional groups have been well engaged throughout the consultation period which took place over nearly 2 months, with over 60 comments received and responded to individually.
- In addition to individual responses to queries the project team will share with all teams a summary of the points which have been clarified through the consultation process. This will accompany the communication of next steps into implementation
- The move to the new model will change the skill mix within teams with an increase in psychological skills and occupational therapy, and less medical and team management and administration.
- This review of current community team roles has enabled a harmonisation of job descriptions and agenda for change bandings across the Trust, which has been supported through Agenda for Change job evaluation processes, and which has been supported by Staff Side and by Professional Leads. For some staff their job banding will change as a result of this process. Individual communications are underway to support colleagues through the transition in line with our Trust policies.
- In line with comments received through staff consultation a phased approach to implementation is planned, ensuring minimal disruption to the continuity of service delivery.

- Recruitment processes will be undertaken in a co-ordinated way to avoid destabilising teams in other parts of our system.
- Equally Staff Side has highlighted the preference of many of their members to proceed swiftly to recruit to posts which have been held pending the agreement of the new workforce model
- A number of clinical and operational queries have been identified through the consultation period which will be monitored carefully through implementation. These include;
    - The ability of the new model to reduce interfaces and handoffs between clinical teams in each service user's journey
    - The impact on continuity of care where service users needs change over time.
    - Balancing levels of resource between 'core' and enhanced' teams in response to demand, and ensuring that the skill mix is optimal in both teams

**1.3 Implementation Phase – Next Steps**

- In the implementation phase the project team will work with all multi-disciplinary teams to support the behaviour change that will be necessary for effective implementation and planned reduction in overall caseload. This will involve:
    - Supporting staff to develop new ways of working (i.e. transition of people back to primary care or co care with primary care, when it is appropriate)
    - Working with Consultants to develop caseloads of about 100, with caseload support from other disciplines
    - Developing an implementation and transition plan with all the multi-disciplinary teams to get to a manageable caseload
- In addition the following work will be required during implementation:
    - Carry out the caseload review to ensure only those patients needing a secondary care intervention are retained on caseloads
    - Work with local GPs to ensure patients can be safely discharged back into the community and provide assurance there's a rapid route back into treatment, if needed
- The phasing of activity within the implementation stage is as follows:
    - June to September
        - Complete communications with individual colleagues regarding the personal impact of the new model on their role
        - Agree redeployment moves between teams

        - Caseload review to identify those patients who will move to new teams, clinicians or be discharged
    - September to April - Create new teams and commence mobilisation
    - By April 2017 – Fully live with new model across the Trust
- Reviews of benefits realisation and of clinical risks identified through the Quality Impact Assessment process will take place throughout implementation and thereafter at 3, 6 and 12 months post-implementation to ensure project objectives have been met and to identify any further efficiencies which can be delivered once the teams are embedded in new cultural practices
- Beyond the implementation of the proposed model, it has been identified through the consultation period that there are additional opportunities to create a richer skill mix in some services through the development of new clinical roles. These opportunities will be taken forward over the next 12 months following establishment of the base new model. Specifically, associate practitioner roles at Band 4 and advanced practitioner roles such as nurse prescribers, nurse (and therapist) consultants and responsible clinician roles beyond Psychiatry. For example developing dual diagnosis expertise in each team.

**1.4 Lead Director Commentary (Karen Taylor)**

The formal consultation period has now ended. Considerable positive feedback has been received through this process, including strong support to progress from staff side. Meetings with medic groups have been held to discuss issues raised.

The next steps planned are sending the formal response to the consultation, planning the implementation, formal preferencing and agreeing the redeployment of staff into new teams.

## 2. Rehabilitation and Recovery

**2.1 The purpose of this project is to:**

- Ensure that the Trust's mental health rehabilitation and recovery services support people needing longer term rehabilitation support as part of their recovery to live in their own community.
- Ensure that where specialist in-patient facilities are required these services are clearly focused on recovery and as close to home as can be achieved within efficiency and quality parameters.
- Achieve greater clarity of purpose for in-patient rehab units. Currently inpatient units meet a wide range of needs, ranging from respite through to acute step down and long term care.

- Enable more people who are currently in placements 'out of area' are able to move back to their local area and into the community.
- Identify potential for reducing in-patient provision and maximising capacity for supporting people in their own tenancies; and improving patient/service user flow within the pathway.

**2.2 Progress to Date:**

- Intensive Community Rehab Support Services now exist in Wakefield and in Barnsley as part of the new community mental health model integrated within existing community teams in the Enhanced Pathway. Work is underway in Kirklees and in Calderdale with Commissioners and other providers of accommodation and support to develop appropriate solutions for local populations.
- Profiling work has been undertaken in Calderdale and Kirklees to establish options for the current cohort of people in Lyndhurst and Enfield Down with an expectation of implementation of new models of care this year.
- Clinical discussions have been ongoing with commissioners about the need for beds in the future service model. Kirklees commissioners have a current preference for eight rehab beds within the SWYPFT footprint, with an additional level of security (i.e. locked rehab). Calderdale commissioners continue to have a preference for local services to operate without NHS beds. Related issues that are being explored include appropriate care for people subject to the Mental Health Act and in relation to the use of Community Treatment Orders.
- All commissioners support the need for enhancing community rehab services to reduce the ongoing need for beds.

**2.3 Lead Director Commentary (Karen Taylor)**

- Agreement has been reached to take forward this project on a locality by locality basis in line with commissioners intentions, maintaining oversight through the trust wide implementation group.

## 3. Older People's Mental Health

**3.1 The purpose of this project is to:**

- Ensure that older people's mental health services are as effective and efficient as possible, with an optimal mix of community and inpatient provision; and the right capacity and capabilities to meet the needs of service users including both dementia and functional mental health need; with clear links to physical healthcare provision to support holistic care.
- Opportunities have been identified for productivity gains in community services, and for more care to be provided in

the community, which in turn will support efficiency and quality enhancement in inpatient settings.

- Ensure that models of care can cope with future demographic pressures
- Build on opportunities for integrated and holistic care e.g. through Vanguard projects and the Kirklees Care Closer to Home contract.

**3.2 Progress to Date:**

- The discovery phase has been completed including identification and quantification of the opportunity for productivity gain, though work with Meridian Productivity.
- Co-design workshops have been well attended by colleagues and stakeholders representing a range of perspectives. Information from the workshops is now being used to inform design activity.
- Memory and community mental health pathways are forming the first phase of design work up to the end of July 2016. Focus will then move to intensive home based treatment before inpatient services.

**3.3 Lead Director Commentary (Karen Taylor)**

We are currently in the process of designing the new service in conjunction with commissioners, services users and our staff.

## 4. Specialist Adult Learning Disability

**4.1 The purpose of this project is to:**

- Provide timely and effective specialist health services for people with learning disabilities who need extra help to live safely
- Improve the quality of services and health outcomes for people with learning disabilities
- Prevent hospital admission wherever possible
- Focus core business on those with the most complex needs

**4.2 Progress to Date:**

- A single specialist community LD health team in each locality is in the final stages of recruitment. All senor posts have been filled and only the band 3 process remains to be completed. This follows the agreement of a new model of care which was consulted on with services users, families, staff and other stakeholders.
- Dedicated MDT's for people with LD and challenging behaviour are in final stages of development, ensuring rapid response to people at times of crisis (including out of hours support).
- Single-points-of-access for specialist LD health services in each locality are being developed.
- Agreements have been reached with local commissioners for the planned and pre-booked purchasing of bed capacity within the Horizon Centre assessment and treatment facility. In addition agreements have been reached with commissioners for the approach to pricing where additional ad-hoc capacity is required. These arrangements provide a stable commercial basis for the operation of the Horizon Centre.
- Net budget reductions of £140,000 have been achieved through the service redesign described above. Further income opportunities are now possible based on the agreement of the pricing approach for the Horizon Centre.
- The third round of engagement activities with service users and carers continued with events held in the Calderdale and Barnsley localities. A final engagement evaluation report will be produced and presented to the next transformation board as part of project handover to benefits realisation stage.
- The next steps in this project are to commence tracking of benefits realisation and to continue monitoring of the clinical and operational KPIs identified through the Quality Impact Assessment process.

**4.3 Lead Director Comments (Tim Breedon)**

The new staffing model remains in implementation phase and good progress has been made on appointments to the new structure. Progress on the implementation plan has been maintained considering local service pressures and increased demand. We are now in the final stages of implementation and the next transformation board will consider when we move project governance into mainstream delivery.

## 5. General Community

### 5.1 Barnsley Administrative Services Review

- This project is remodeling the inpatient and reception administration functions across Barnsley BDU's main sites (Kendray and MVH) to reduce inefficiencies and duplication.
- This will provide an administrative service that is flexible and responsive. It will also establish clear career development pathways and apprenticeship opportunities.
- Phase one of implementation, focusing on community inpatient services, has begun and staff consultation is set to commence before the end of June 2016. It is estimated that this will achieve savings of £52k.

### 5.2 Therapy Services Review

- The purpose of this project is to establish Therapy clinical centres with appropriate satellite clinical provision.
- Progress so far is that the Children's Therapy service has relocated from rented Acorn Centre in Grimethorpe to Mount Vernon Hospital.
- Three mini administration hubs (New Street, Mount Vernon and Physiotherapy Outpatients) are now in place.

### 5.3 Barnsley Community Nursing Transformation

- The purpose of this project is to ensure the right person, right contact, and right time; and to equip more patients to self-care
- Better integrate community nursing and care navigation teams.
- Establish a clear operating framework working in defined localities which align with primary and social care.
- This is being developed in conjunction with local commissioners in response to a new community nursing service specification which aligns community nursing with primary care and place based collaborative working.
- In response to the service user engagement activities held in 2015/16 and the issue of the new specification, a service architecture event, co-produced by SWYPFT and Barnsley CCG, was held in May 2016.
- In June 2016, a staff engagement event was well attended and provided SWYPFT staff with an opportunity to view the suggested service architecture that came out of the event held in May and provide feedback directly to senior management.

### 5.4 Diabetes Medicine and Respiratory Medicine

- New integrated pathways are being developed with local partners Barnsley Hospital NHS Foundation Trust and Barnsley Healthcare Federation.
- The new pathways will support revised contracts to incentivise providers to collaborate to help people with long term conditions to stay well, and to reduce hopitalisation. This is part of the movement towards an

accountable care system for Barnsley.

### 5.5 Lead Directors Comments (Sean Rayner)

For nearly all general Community Services Service Lines provided from the Barnsley BDU, they are either subject to Commissioner-led Service Specification Review/Changes or a formal Service Review as part of the Contractual Service Development & Improvement Plan (SDIP). This is in addition to internal Transformation/Service Improvement work. The progress and outcome of all this activity is being co-ordinated by the Transformation Programme Board, which has Staff Side representation on it.

# Trust Board 28 June 2016
# Agenda item 6.3(ii)

| | |
|---|---|
| **Title:** | **Incident management annual report 2015/16** |
| **Paper prepared by:** | Director of Nursing, Clinical Governance and Safety |
| **Purpose:** | The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust. |
| **Mission/values:** | The report demonstrates the Trust's commitment to delivering safe and effective services. |
| **Any background papers/ previously considered by:** | Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. The full report and this summary report have been reviewed in detail by the Clinical Governance and Clinical Safety Committee. |
| **Executive summary:** | The Trust showed a 13% increase in incidents reported on the previous year. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture (NPSA Seven Steps to Safety).<br><br>The number of incidents reported across the Trust has increased although the overall proportion of more serious incidents is a lower proportion of all incidents than last year. The number of apparent suicides has decreased from last year from 45 to 41.<br><br>During 2015/16 there have been no 'never events', no homicides nor has the Trust been issued any section 28 letters by the Coroner.<br><br>The Trust is reviewing the detail of any action that may be required as a result of the Care Quality Commission (CQC) visit; however, its report does state that "staff had a good understanding of the incident reporting procedure. The staff we spoke to at ward and board level confirmed they received feedback and learning from incidents".<br><br>The Trust continues to focus on learning lessons from incidents and is rated as 'good' in this area when benchmarked against Trusts nationally.<br><br>The report makes reference to the learning that takes place when an incident occurs. Further details of this work is described in the 'learning lessons' report that was introduced during 2015/16 and will continue in 2016/17.<br><br>The Trust continues to implement the **Patient Safety Strategy,** including national *Sign up to Safety* initiative, ensuring duty of candour is embedded and monitored, Safewards, and developing ways of capturing and sharing lessons learned. In support of the Strategy, the Trust will implement and monitor its **Suicide Prevention Strategy** action plan.<br><br><u>Next steps</u><br>• To further develop processes for measuring the impact of serious incident action plans and learning events by capturing evidence of positive change whether in terms of the quality of care provided, a measurable change in safety culture or a reduction in the frequency or severity of incidents.<br>• An external review of twelve serious incidents by National Confidential Inquiry into Suicide and Homicide. |

| | |
|---|---|
| | • Collaboration with the CQC review of incident management in response to deaths and consider approaches to reviewing mortality.<br>• To review of policies relating to the Trust's serious incident framework.<br>• To use feedback from users to improve the Datixweb experience for users.<br>• To network with other Trusts across West Yorkshire.<br>• Future reporting to Trust Board will combine wider patient safety issues, including a review of incidents, learning lessons and progress in implementing the Patient Safety Strategy. |
| **Recommendation:** | **Trust Board is asked to RECEIVE the annual report on incident management and to NOTE the next steps identified.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Summary Review of Incident Management Annual Report

## April 2015 to March 2016

**Patient Safety Support Team**

**June 2016**

With **all of us** in mind.

**Introduction**
This report provides a summary of the detailed incident management annual report April 2015 to March 2016. The report covers incidents reported within the Trust on the incident management system (DatixWeb).The report will present key headline data, brief analysis, and a summary of work undertaken during the year and some of the key next steps planned for 2016/17.

The report does not cover incidents that are managed through other processes such as safeguarding and serious case reviews (safeguarding report) or whistleblowing (staff survey).

A separate report is being produced.to cover the work of the BDUs in terms of implementing the learning; this will be completed during quarter 2.

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

The patient safety support team is working with clinical services to deliver the 5 pledges made within the patient safety strategy as part of the national Sign Up to Safety campaign.

- ***We aim to develop a trust-wide patient safety strategy with the primary aim of preventing harm and making safety a priority for all staff"***

- *We will foster a culture of learning from patient safety incidents and demonstrate real changes in practice as a result of this learning.*

- *We will be open with patient and carers when harm has occurred, share lessons learned and communicate what we've done to stop it happening again.*

- *We will maintain and develop our links with key stakeholders and establish links with patient safety networks locally and nationally.*

- *Patients, carers and staff will be offered support which meets their individual needs after untoward incidents.*

**External scrutiny and feedback**
<u>Mazars audit into serious incident management at Southern Health NHS Foundation Trust</u>
A draft report by independent auditors Mazars, commissioned by NHS England, was leaked to the BBC in December 2015. The report comments on services run by Southern Health NHS Foundation Trust, which covers Hampshire, Dorset,

Oxfordshire, Wiltshire and Buckinghamshire. The leaked report, found failings in the way the Trust investigated serious incidents. The review was commissioned by former NHS England Chief Executive, Sir David Nicholson, after the preventable death of one of the Trust's patients, Connor Sparrowhawk, in 2013.

The issues and implications for SWYPFT arising from the audit report were reviewed and reported to the Trust Board in February 2016. Serious and far reaching concerns were identified in the external audit of incident management in Southern Health NHS Foundation Trust. This has led the Department of Health to commission a national review of incident reporting in mental health and learning disability services in addition to action taken by Monitor. At SWYPFT, there is a comprehensive policy on the reporting and investigation of incidents that operates in accordance with national guidance and standards. The Trust will fully comply with the CQC national review findings and are considering possible approaches to conducting mortality reviews. In the interim and on an ongoing basis, the Trust will continue to monitor its compliance with national guidance and ensure that the quality of its investigations and serious incident reports remains high.

**Learning from Mistakes Benchmarking**

In December, following problems at Southern Health, NHS Improvement gathered data from various health care organisations and in March 2016 published Learning from Mistakes ranking of NHS Trusts
https://www.gov.uk/government/publications/learning-from-mistakes-league

The league table has been drawn together by scoring providers based on data from the 2015 NHS staff survey and from the National Reporting and Learning System. The Trust was ranked 117/230 and in the good category. This means there were no concerns/flags in relation to NLRS or the staff survey but we were not in the top 20% on any of the criteria.

This will be updated every year in a new Care Quality Commission (CQC) State of Hospital Quality report that will also contain trusts' own annual estimates of their avoidable mortality rates and have a strong focus on learning and improvement.

The Trust needs to continue with the same quality and timeliness of reporting onto National Reporting and Learning System to ensure it does not pick up an alert flag for this work. It also needs to continue to action plan against related areas on the staff survey. To improve the Trust position it would need to be in the top 20% of Trusts on one of the 3 criteria but certainly not to drop further down resulting in a flag which would drop the rank to cause for significant concern.

A number of questions are asked within the **National Staff Survey 2015** which provided direct feedback on staff views with regards to the incident reporting system. The 2015 staff survey published in 2016. For full report:
http://nww.swyt.nhs.uk/wellbeing/nhs-staff-survey/Pages/default.aspx

A number of questions are asked within the Staff Survey 2015 which provided direct feedback on staff views with regards to the incident reporting system. The 2015 staff survey published in 2016

reported that the Trust was in line with the National average for combined Mental Health, Learning Disability and community Trusts with the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (22%) and percentage of staff reporting errors, near misses or incidents witnessed in the last month (91%), an improvement on 2014 data.

Areas that require further examination with the Business Delivery Units (BDUs) are Fairness and effectiveness of procedures for reporting errors, near misses and incidents and staff confidence and security in reporting unsafe clinical practice, both lower than the national average falling into the bottom five ranked results for the Trust.

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

**Homicide Independent Reviews**

There were three homicide independent investigations that were concluded during 2015/16. These were historical cases from 2010/11. A themed analysis took also took place, covering these three homicides and three previous homicides in 2007/8. The actions plans have been completed; all of which have been closed by commissioners and sent to the Local Area Team for closure; the Local Area Team has closed one at time of writing this report.

During 2015/16 the Trust has been involved in two independent investigations as a stakeholder. One relates to a patient of the Trust (Calderdale) who was transferred to a private provider where she was murdered. The investigation report is due for completion in Quarter 2 2016/17. The second one is in relation to a patient from Forensic services who was discharged in 2009; this investigation has just started.

**Learning from incidents**

The Trust continues to explore ways in which it can learn from incidents of all grades.

All staff with user access to Datix across the Trust now also has access to a Dashboard displaying information for their area of responsibility. This built on work completed in 2014/15 to roll Dashboards out to Consultants. Dashboards visually reports on real time data about incidents, themes and trends.

Datix was upgraded in October 2015, enabling new features to be introduced to aid staff. One of these was ‘Pinned Queries’ which enables Datix users to quickly access specific groups of incidents, such as where Duty of Candour is applicable, or investigations are awaiting completion.

A new feature where staff can request feedback from an incident they reported has been developed in 2015/16 and has been implemented in April 2016, supporting staff with closing the loop.

The patient safety support team facilitate learning events following serious incidents and BDU also hold wider learning events examining themes and learning from incidents.

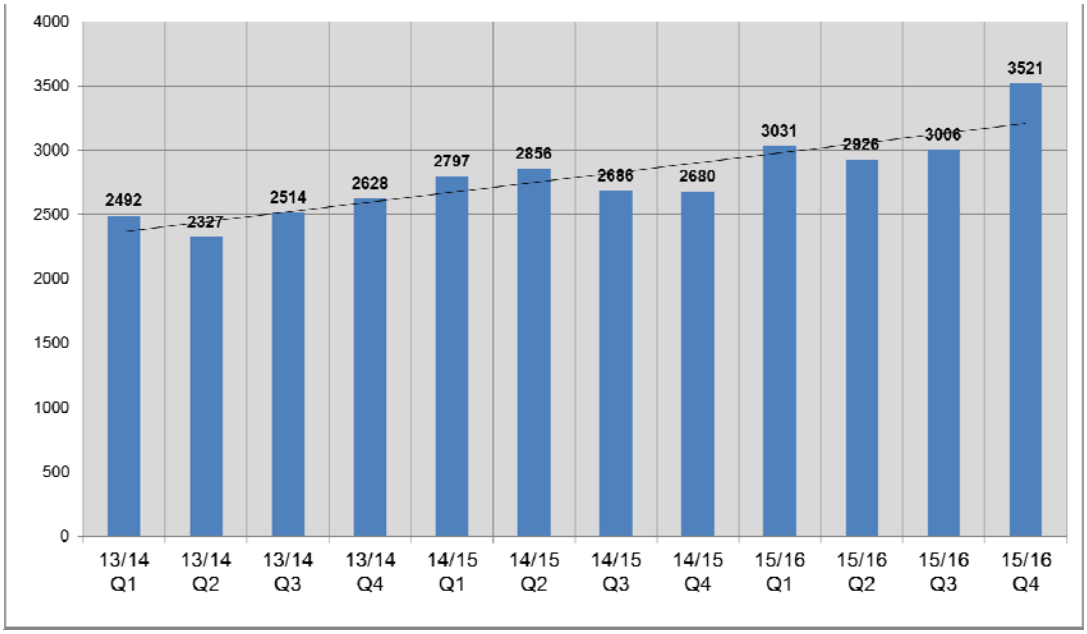
The investigators are working with the practice governance coaches to produce a report for each BDU on the learning from incidents; these will be available in quarter 2 2016.

The Patient Safety Support Team has developed a range of training options including video guides, user guides, coaching, individual and group sessions covering a range of content.

**Headline data**

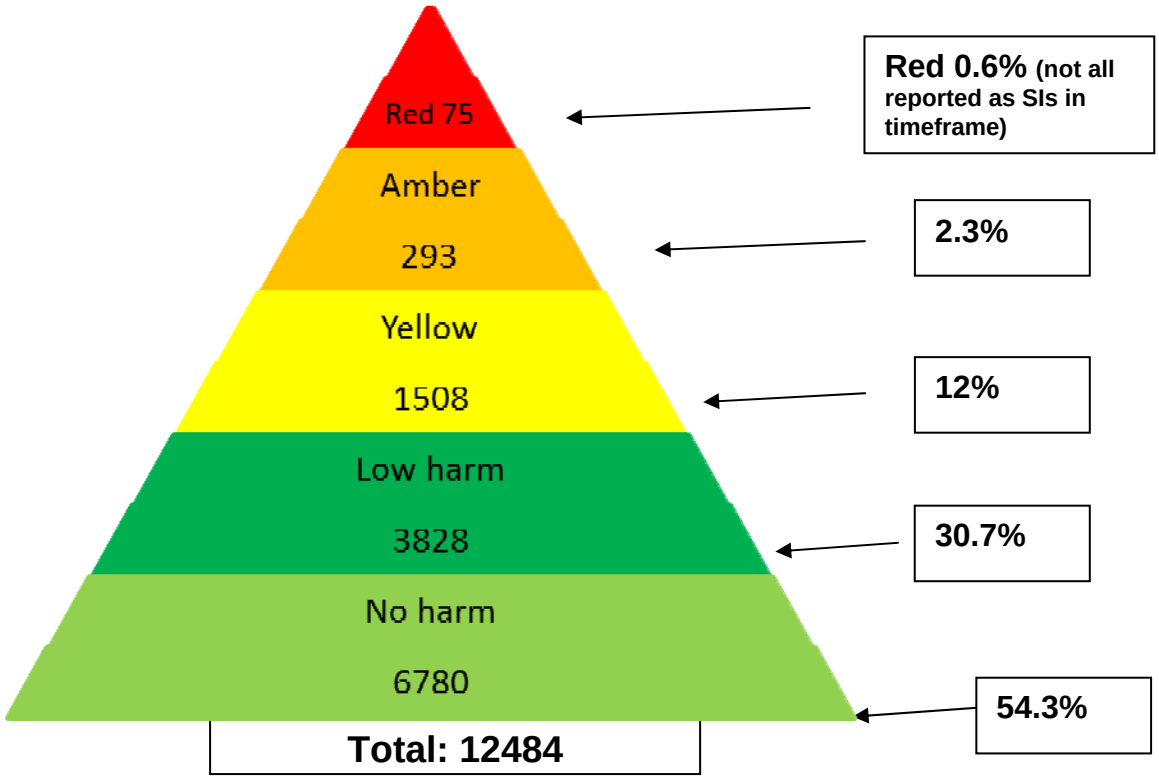
The Trust reported **12484** incidents of all severity during the year, a 13% increase on 2014/15 (1494 additional incidents being reported). The range within a quarter is 2926-3521 incidents.

Comparative number of incidents reported by financial quarter 2013/14 to 2015/16




The distribution of these incidents in terms of severity is pyramid-shaped, serious incidents being fewest in number; with most incidents (85%) resulting in no/low harm. an organisation with high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture.

Incidents reported by severity 2015/16

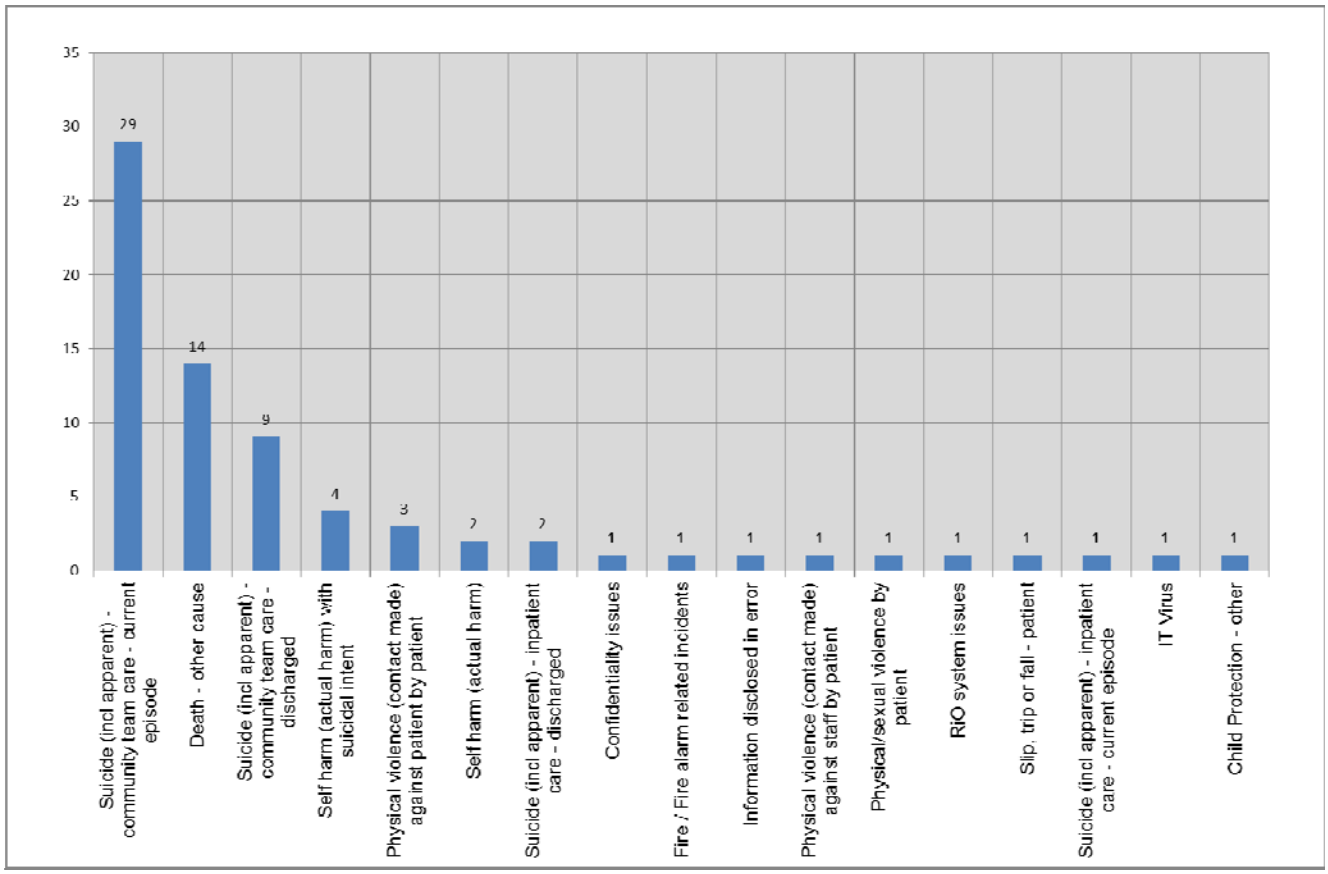



Serious incidents are defined by NHS England, they are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. There is no definitive list of events/incidents.[1] There is a definition of the circumstances a SI should be declared.

During 2015/16 **76** serious incidents were reported to the commissioning CCGs via the Department of Health database, STEIS. This is a reduction overall on 2014/15 (103) which is due to changes in the way pressure ulcers are reported. In 2015/16 3 pressure ulcers were reported, compared with 34 in 2014/15. Those reported were attributable to SWYPFT care and were deemed avoidable. When pressure ulcers are excluded, the figures for the year (73) are comparable with the previous year (72).

[1] Serious incident Framework NHS England March 2015

**Chart 1-Serious incidents (excluding pressure ulcers) by type 2015/16**




**Never Events** are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no 'never event' incidents reported by SWYPFT in 2015/16.

There were **no homicides** reported in 2015/16.

**External comparison**

During the year, the patient safety support team uploaded 6110 patient safety incidents (at the time of the report) to the National Reporting and Learning System (NRLS) to contribute to national learning and benchmarking data. 96% of these incidents resulted in no or low harm.

There are limited opportunities to compare the Trust data but where this is available it indicates the Trust has a strong safety culture. The NRLS Team produce six-monthly reports comparing mental health trusts. There are limitations with this data, in that SWYPFT is compared with Trusts providing only mental health services, whereas the Trust also provides community services and has a large forensic component. Subject to this caveat, the latest report for April–September 2015 shows the Trust remains in the middle 50% of reporters, with a reporting pattern for numbers of incidents in particular categories similar to other Trusts. However the Trust has reported more no harm incidents (76.3%) compared with the mental health cluster (62.1%) and nationally (72%).

The Trust was also part of a number of national benchmark exercises including mental health, community services, restraints and Learning Disability Census.

**Internal comparison**

The patient safety support team has undertaken analysis of all serious incidents that have been reported by category, team, month and year within the full report. There are no obvious trends by teams or category from previous years. Chart 1 above shows the 73 serious incidents (excluding pressure ulcers) by category of incident.

i) Apparent and actual suicide

The largest single category at the time of reporting the incident was apparent suicide, with 41. This is slightly lower than last year, (2014/15) when the total was 45 however other unexpected deaths have increased (see comments further in the summary). The reporting criteria are incidents which include current patients or someone who has been discharged within the last 12 months; these incidents are reviewed by a weekly risk panel to determine whether they require reporting on Strategic Executive Information System (STEIS). 70% of apparent suicides were of service users who were in current contact with services at the time of death (29). There are a further 12 apparent suicides recorded separately, such as where the service user was discharged from mental health services within 12 months of the date of their death, or who was or had been under the care of inpatient services at the time of death. Adult Community Mental Health Teams remains the type of team reporting the most apparent suicides (19 of the 41).

This type of SI was most frequent in working aged adult services, and most suicides were by service users in contact with community services or discharged from services. This is consistent with national findings (NCI data). The main method of suicide is hanging, which again is in line with the national data.

The Trust will not know for a few years if this increase is in line with a national picture, as National Confidential Inquiry is based on data two years behind and the latest information covered 2013. It is of note that there is likely to be an increase in suicide nationally and locally due to prevailing socio-economic factors (Coroners statistics, 2011; NCI, 2015, Ministry of Justice 2016).

**Chart 2** 2015/16 apparent suicides broken down by BDU and method indicated at time of reporting.

| Method indicated at time of reporting | Barnsley Mental Health and Substance Misuse | Calderdale | Kirklees | Wakefield | Forensic Service | **Total** |
|---|---|---|---|---|---|---|
| Hanging - self injury | 4 | 0 | 9 | 4 | 0 | **17** |
| Jumping from height - self injury | 1 | 1 | 3 | 1 | 0 | **6** |
| Method unknown - self injury | 1 | 1 | 1 | 1 | 0 | **4** |
| Other - self poisoning | 0 | 0 | 2 | 2 | 0 | **4** |

| Method indicated at time of reporting | Barnsley Mental Health and Substance Misuse | Calderdale | Kirklees | Wakefield | Forensic Service | **Total** |
|---|---|---|---|---|---|---|
| Contact with moving vehicle (car, train) - self injury | 0 | 1 | 1 | 0 | 1 | **3** |
| Cutting - self injury | 0 | 1 | 1 | 0 | 0 | **2** |
| Prescription medication - self poisoning | 0 | 0 | 1 | 1 | 0 | **2** |
| Burning - self injury | 0 | 0 | 0 | 1 | 0 | **1** |
| Drowning - self injury | 0 | 0 | 0 | 1 | 0 | **1** |
| Shooting - self injury | 0 | 0 | 1 | 0 | 0 | **1** |
| **Total** | **6** | **4** | **19** | **11** | **1** | **41** |

Chart 3 shows the number per 100,000 population of **all** serious incidents reported by the Trust in the geographical areas shown below (Trust-wide service/corporate incidents are excluded) ranging from 4.33 to 6.96 dependent on the BDU.

Using population size and national confidential inquiry data (expected rates), based on SWYPFT geographical area and population would expect approximately 34 patient deaths by suicide per year. The annual report breaks this down by BDU and type and shows the previous year for comparison. The apparent suicides over the last four years average out at 35 per year.

**Chart 3**

| District | Population ONS – population estimates Mid 2014 | General population suicide rate (NCI) 10.1 per 100,000 | Patient suicide rate (28% general pop) (NCI) | Apparent suicide reported on STEIS 2014/15 | Apparent suicide reported on STEIS 2015/16 | All SI Incident figures per 100,000 population for 2014/15 | All SI Incident figures per 100,000 population for 2015/16 |
|---|---|---|---|---|---|---|---|
| **Barnsley** | 237,843 | 24 | 7 | 11 | 6 | 6.36 | 5.04 |
| **Calderdale** | 207,376 | 21 | 6 | 8 | 4 | 6.78 | 4.33 |
| **Kirklees** | 431,020 | 43-44 | 12 | 16 | 19 | 4.44 | 6.96 |
| **Wakefield** | 331,379 | 33-34 | 9 | 10 | 11 | 5.76 | 5.43 |
| **Trust-wide** | 1,207,616 | 122 | 34 | 45 | 40* | | |

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

Again this information must be viewed with caution, because the Trust does not have access to the local actual general population data. The table shows the reported expected incidence of suicide in SWYPFT by BDU based on BDU populations and the NCI data. These NCI figures do not reflect socio-economic or other factors that

might influence suicide rates and are simply averages of the data collected. NCI 'patient' data includes all cases where the coroner gave a verdict of suicide or an open verdict for any person who had been in current contact with mental health services or in contact in the preceding 12 months. The numbers for Kirklees and Wakefield are higher than expected and reported last year, and Calderdale and Barnsley figures are less than the number expected and less than reported 2014/15.

The chart below show both serious incidents and apparent suicides against the trust wide mental health contact data. SIs occurring in non-mental health/trust wide services (corporate, specialist services, forensics) have been excluded from the comparison.

**Chart 4**

| District | Mental health number of service users who have had one or more contacts 2015/6 | Serious Incidents figures per 10,000 contacts* | Apparent suicide figures per 10,000 contacts |
|---|---|---|---|
| **Barnsley** | 13056 | 6.9 | 4.59 |
| **Calderdale** | 4967 | 18.12 | 8.05 |
| **Kirklees** | 14345 | 20.9 | 13.25 |
| **Wakefield** | 10043 | 17.92 | 10.95 |
| **Trust-wide –mental health** | 42411 | 15.56 | 9.43 |

**Serious incident figures based on 66 incidents that were linked to BDU mental health.*

The following tables show further analysis of the 41 apparent suicides:

Apparent suicides - current or discharged service user at time of death:

| **Status at time of death** | |
|---|---|
| Current service user | 30 |
| Discharged service user | 11 |

| **Care Programme Approach** | |
|---|---|
| CPA | 20 |
| Standard Care | 10 |
| Not applicable | 11 |

*N/A includes discharged patients

| **Detained under the mental health act** | |
|---|---|
| Detained under MHA | 0 |

Although none of the deaths were of detained patients, there were four other incidents (not resulting in death) where the patient was detained under the Mental Health Act. These were three violence and aggression incidents, and an inpatient fall.

**Chart 5:** Apparent suicides reported as SIs during 2015/16 - by gender and age

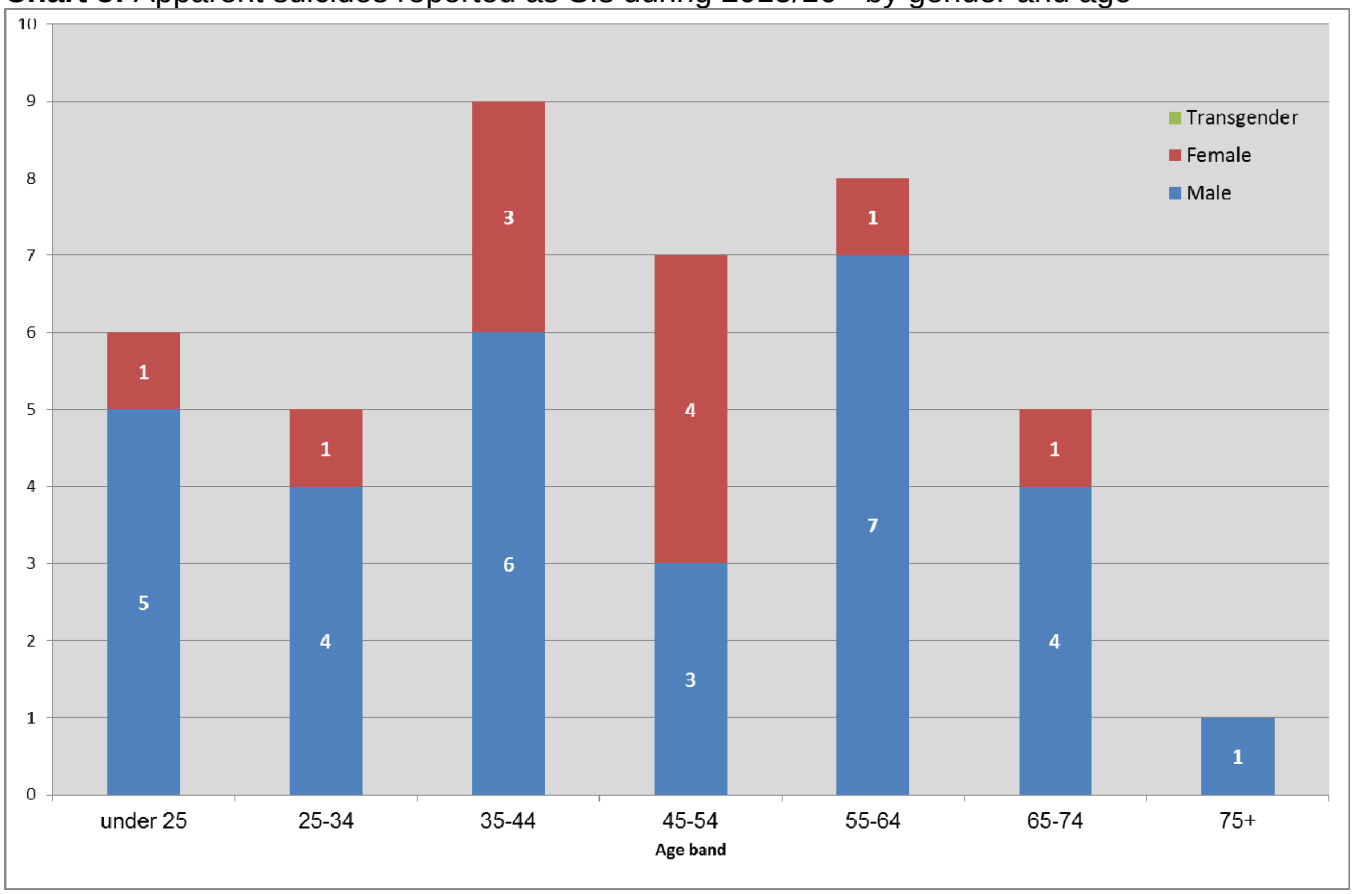



**Chart 5** shows the gender and age distribution of all apparent suicides reported during 2015/16. There were no transgender service users. Of the 41 suicides/suspected suicides, (11 female,30 male) In terms of age, the highest proportion of apparent suicide in males occurred between the ages of 55-64 (17%), followed by 35-44 age band (15%). This age band (35-44) was the highest overall, accounting for 22% of all suicides/suspected suicides. Overall, suicides/suspected suicide of females were much lower at 27%, occurring across all ages with the exception of 75 and over. The highest age band for suicides and suspected suicide in females was the 45-54 age range.

Based on the National Confidential Inquiry data from July 2015, we would expect 23 deaths by suicide for males and 11 for females (data up to *2013*), a total of 34. The number of female apparent suicides was a match with expected national numbers but male apparent suicide was higher at 30.

The National Confidential Inquiry July 2015 showed the pattern of male suicide rates during the report period varied by age-group. Since 2003, there has been a fall in male suicide rates in those aged 25-34 and 65 and over; an increase in those aged

45-54 and 55-64; and no change in those aged under 25 or 35-44. The rise in suicide in men aged 45-54 since 2006 is 37%, in men aged 55-64 it has been 29%. This age range (55-64) is the highest within the Trust.

In females, rates fell in those aged under 25, 25-34 and 65 and over. These changes have been substantial and largely maintained year on year.

Apparent suicides (discharged patients) - number of days between last contact with services and the death occurring

| Number of days between last contact with services and death | Number of deaths |
|---|---|
| 0-30 days | 3 |
| 31-60 days | 4 |
| 61-90 days | 2 |
| 91-120 days | 2 |

**Death – other causes**

Fourteen serious incidents were reported relating to the unexpected death of service users which has increased over recent years (11 in 2014/15, 8 in 2013/14). Unexpected deaths include deceased patients where the cause of death is unclear or accidental. In 2015/16, 10 of the 14 were deaths of community patients found deceased at home. Another example is an inpatient in an Older People's ward was found unresponsive; the cause of death was later identified as 'Pulmonary Thromboembolism, Deep Vein Thrombosis'. It can take a significant amount of time for the cause of death to be identified through the coroner's office. However, irrespective of the outcome, this does not prevent the investigation being completed.

When received, the cause of death may not be related to a patient safety issue. Of the 14 unexpected deaths, information received to date (8/5/16) indicates that:

**Actual cause of death**

| Cause of unexpected death | Number |
|---|---|
| Deaths related to substance misuse including prescribed and illicit drugs, and alcohol | 8 |
| Overdose - but not known if accidental or deliberate | 2 |
| Pulmonary Thromboembolism, Deep vein Thrombosis | 1 |
| Aspiration of stomach contents (accidental death) | 1 |
| Unknown to the Trust | 2 |

**Self-harm/attempted suicide**

There were 6 serious self-harm incidents reported during 2015/16, consistent with 2014/15.

The incidents included 2 incidents of burning (Kirklees RAID and Wakefield CMHT), 2 jumping from a height (Wakefield EIS and Barnsley CMHT), and 2 self-poisoning with prescribed medication (Kirklees CMHT Adult and CMHT OPS).

**Violence and Aggression**

During 2015/16 there were 5 violence and aggression incidents. Four of the 5 occurred in inpatient settings. The fifth incident occurred in the community relating to sexual violence by a patient against another person, reported by AOT (Kirklees). The inpatient incidents were 2 Physical violence by patient against patient with weapons. These occurred in Forensic (pool cue), and Kirklees inpatient unit (razor - this was a near miss). There was a further Physical violence by patient against patient without weapon in Calderdale OPS, and Physical violence by patient against staff without weapon in Learning Disability Services.

**Safeguarding**

During 2015/16 there was one safeguarding children issue reported as a Serious Incident. This related to safeguarding concerns regarding the death of an unborn child. This did not meet the criteria for a Serious Case Review.
Note Serious case reviews are reported through the Safeguarding annual report.

**Fire**

During 2015/16 there was one fire related serious incident reported by Wakefield community services (EIS) where a service user was arrested for arson with attempt to endanger lives.

**Falls**

There was one inpatient fall (Kirklees OPS) resulting in fractured neck vertebrae and bleeding to brain that resulted in reported as a serious incident.

**Information Governance (IG) and Information Technology (IT)**

Information Governance and IT incidents which have a score of 2 or above on the Department of Health (DOH) table are managed as a Serious Incident (reported on STEIS) and also reported to the Information Commissioner as a SIRI.

**Pressure ulcers**

During 2015/16, a total of 3 Pressure ulcers grade 3 or 4 were reported as Serious Incidents on STEIS. These were all Grade 3 pressure ulcers reported by District Nursing teams in Barnsley General Community Services. These incidents are recorded with an amber severity (Major serious injury, impact or intervention) on the Datix System.

In February 2015, the reporting requirements for pressure ulcers were changed by the Local Area Team in order to standardise reporting across the South Yorkshire region. The revised criteria is now to report only avoidable pressure ulcers that are attributable to care provided by SWYPFT. In SWYPFT all attributable pressure

ulcers are reviewed at a monthly meeting against standard good practice criteria. The group decide if the pressure ulcer was avoidable or not. Those that are avoidable are then reported on STEIS as Serious Incidents and investigated further. Comparison of 2015/16 data with previous years cannot be made due to changes in the reporting requirements.

**Duty of Candour**

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

233 incidents were applicable 2015/16 (1.8% of all incidents reported). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death has increased during each quarter of the financial year. However, incident reporting has also increased over the year. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter has remained fairly similar. Improvements have been made to the process, recording and training has been delivered to over 200 managers during February 2016.

**Investigations completed during 2015/16**

During the period 1 April 2015 to 31 March 2016, 69 serious incident investigation reports were submitted to the relevant commissioner (please note this is not the same data as those reported in this period as investigations take a number of months to complete). Of these 69, 13 investigations were submitted within the original timescale.

Of the remaining SIs, 52 resulted in requests for extensions from the commissioner. The reasons for extension are varied but include:-

- Capacity of team, the team was carrying a vacancy for five months for a lead investigator
- Complex investigations involving a number of agencies
- Access to staff (12 hour shift has made this difficult)
- Internal delays of governance procedures –setting up meetings, Director review of reports, further investigation/clarity required in reports.
- Families contacting investigation team wishing to be involved late in the process, the teams would always request an extension to facilitate this.
- Awaiting information from Coroner or external parties.

To try and reduce the number of extensions the investigation team along with the Medical and Nursing Director have reviewed the process utilising lean methodology. The process now includes a 25 day internal review of the investigation.

Any extension is agreed with the Commissioners and an interim report is submitted. The investigators also keep families informed.

**Governance structure**

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

The Clinical Governance and Clinical Safety Committee ensure robust scrutiny on behalf of the Board. The Committee receives performance information; this includes a detailed quarterly report for each BDU alongside a serious incident report. The Committee also received the learning journey reports that are produced every six months, these capture the implementation and learning from incidents.

The bi-monthly patient safety clinical reference group meetings, chaired by the AMD for patient safety, is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety.

Following publication of the Trusts Patient Safety Strategy, the Patient Safety Strategy Implementation Group has been established the year, the purpose of the group is that it aims to ensure the implementation, monitoring and evaluation of the Trust strategy. It is a dedicated action-orientated group to include key stakeholders that will regularly monitor progress and evaluate outcomes arising from the strategy. The outcome is to improve the safety culture throughout the organisation. Reduce the frequency and severity of harm resulting from patient safety incidents. Enhance the safety, effectiveness and positive experience of the services we provide. Reduce the costs both personal and financial associated with patient safety incidents.

Suicide Prevention Strategy Group is in the process of being set up following the publication of the Trust strategy.

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

1. <u>Findings from serious incident investigations</u>

A majority of the recommendations from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator is working with the BDUs in producing a report on learning from recommendations.

There were a total of 69 Serious Incident investigation reports submitted to Commissioners between 1st April 2015 and 31st March 2016 (the data set is different from incidents reported as incidents are not always completed in the financial year they are reported). Four of these related to avoidable pressure ulcers. Pressure

ulcer SIs follow a separate process to other SIs. The pressure ulcer reports resulted in 4 action plan, leading to 14 recommendations being made, summarised below:

- To promote and improve communication between agencies.
- Providing training for care homes on pressure ulcers
- Training for staff on heel care
- Sharing information about Waterlow assessments
- Identifying a link nurse for tissue viability on a ward.
- To share learning from the incidents with colleagues across teams

For the other 65 Serious incident investigation reports completed and sent to the commissioners in this period (2014/15 = 66 sent), 44 resulted in an action plan. These 44 action plans led to 113 recommendations being made. In 2014/15 the 66 reports sent resulted in 176 recommendations. In 2015/16, 21 investigations made no recommendations, an increase on 2014/15 when 16 investigations made no recommendations. This is a positive sign that learning from incidents is occurring are learning and ensuring care delivery is safe and of a high standard despite the outcome.

In 2015-16 the most frequent three recommendation types were as follows.

**Organisational systems, management issues**
Organisational systems and management issues has remained one of the top three types of recommendations. Following an IT virus, there were a number of recommendations made to improve major incident communication, processes, Trust wide business continuity and other work procedures. An IG breach led to a number of Trust wide recommendations to improve the recording of consent and access to records. Other clinical incidents led to recommendations to ensure learning from incidents is used to support the Trust's review of the discharge policy; ensuring the Trust is compliant with NICE and Trust antidepressant guidance; improving liaison between the Trust and Drug & Alcohol Services to enable sharing patient information; teams to evaluate their service delivery against Trust wide Standard Operating Procedures (IHBTT), and SPA reviewing its operational policy within the Trust wide Transformation policy.

**Record keeping:**
Record keeping has remained one of the top three types of recommendation for the last five years.

Many recommendations relate to accuracy and completion of recording in clinical records, such as ensuring all retrospective entries are clearly identified as such; notes relating to service users are recorded at the Multi-Disciplinary Team Meeting and should be documented in the progress notes on RiO; accurate and comprehensive Crisis and Contingency Plans; team members who undertake observation and engagement levels complete documentation; relevant information is recorded on the appropriate assessment documentation; all clinical discussions related to service user care should be recorded in the written or electronic records; comprehensive assessment should include full details of the risk in the free text boxes of the assessment; attempts should be made to obtain all service user notes/documents/GP records.  Other issues included ensuring that audits into the

quality of medical care plans takes place, and when an inpatient Consultant Psychiatrist is not available, appropriate systems should be in place to ensure that all discharge summary letters completed by junior doctors are checked. A recommendation that spanned a number of themes was to use existing reporting data to ensure that standards of practice relating to care delivery are reviewed through supervision.

**Care delivery**

Care delivery has moved into the top three recommendation types. A number of care delivery issues related to an inpatient setting, and included ensuring that if inpatient admission is due to high risk of suicide, follow up within 48 hours of discharge is advised; any in-patient should be reviewed as a priority by the medical team, prior to the use of leave off the ward; developing a feedback process that gathers views of patient and significant others following leave; clarifying and recording plans for leave prior to leave commencing; checking conditions of leave; when there are significant changes in presentation and / or risks, service user will be booked in for Inpatient Review. Other issues included reviewing procedures to ensure the commencement of early treatment for service users where a mental disorder is suspected; where a service user who has a mental health diagnosis commits serious criminal acts such as arson, the reasons for these should be explored, documented and then considered to see if a referral to the Forensic Psychiatric Service is needed; a review of medical treatment should be part of a Care Plan for those with complex presentation, developed in collaboration with the multidisciplinary team and the patient.

Work to ensure monitoring and implementation of all Serious Incident action plans continues.

**Learning lessons and Safety Culture**

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

Each BDU has a Lead Investigator who is responsible for working with BDUs on such subjects as learning from incidents, using Datix to assist with such learning. They also have a practice governance coach (or personnel with a similar role) to assist in the dissemination of learning arising from SIs. They work closely together to enable learning closer to frontline staff and provide greater opportunities to capture the impact of learning. Every SI investigation is followed by a learning event for the individual team or service involved. In addition, BDUs have held wider learning events for staff to highlight themes and trends from incidents (both serious and otherwise) along with lessons learned. Lead Investigators have supported these events and provided presentations.

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

Plans for 2016-17 include:

**Patient Safety Strategy**: continued implementation of patient safety strategy including:-

- national *Sign up to Safety* initiative
- ensuring duty of candour is embedded and monitored
- Safewards
- Developing ways of capturing and sharing lessons learned

**Suicide Prevention Strategy**: to support the suicide prevention lead with implementation and monitoring of the action plan.

- Further develop processes for measuring the impact of SI action plans and learning events by capturing evidence of positive change, whether that be in terms of the quality of care provided, a measurable change in safety culture or a reduction in the frequency or severity of incidents.
- Continue to support research.
- We are reviewing the detail of any action that may be required as a result of the CQC inspection visit; however the report does state that “staff had a good understanding of the incident reporting procedure. The staff we spoke to at ward and board level confirmed they received feedback and learning from incidents”.
- Continue to work with a speciality trainee who is examining how Datix can be used to support identifying systems and processes involved from recommendations made.
- External review of 12 Sis conducted by NCISH
- Collaborate with CQC review of incident management in response to deaths and consider approaches to reviewing mortality
- Review policies in relation to Serious Incident Framework

**Datix**

- Implement future Datix release upgrades and exploit the features available to support safety
- To maintain the Datix dashboard configuration and monitor additional requests
- Continue with Datix system audits
- Enable and support the implementation of Security Incident Reporting System (SIRS) to upload violence against staff and security incidents to NHS Protect through Datixweb
- To use feedback from users to improve the Datixweb experience for users
- Networking with other Trusts across West Yorkshire

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Trust Board 28 June 2016
# Agenda item 6.3(iii)

| | |
|---|---|
| **Title:** | **Customer Services annual report for the financial year 2015/16** |
| **Paper prepared by:** | Director of Corporate Development |
| **Purpose:** | This report supports Trust Board scrutiny of feedback through the Customer Services function, including complaints about care and treatment. |
| **Mission/values:** | Good customer service underpins all the Trust's values and is central to fostering and maintaining a culture of continuous quality improvement and an improved experience and outcomes for people who use services. |
| **Any background papers/ previously considered by:** | The Trust Board also receives quarterly reports on Customer Services activity. BDUs receive weekly reports on complaints received and closed. |
| **Executive summary:** | This report covers the financial year 2015/16 and gives an overview of issues raised through the Customer Services function during the period.<br><br>The Trust aims to improve the experience of people who use services by responding positively to feedback and resolving issues as they happen whenever possible and at every level in the organisation. During the period covered by the report:<br><br>➢ 342 formal complaints were investigated, with learning shared as appropriate;<br>➢ seventeen cases (5%) were raised with the Parliamentary and Health Service Ombudsman, with two upheld and one partially upheld in the period;<br>➢ 351 informal concerns, 579 enquiries and 124 comments were made;<br>➢ 672 compliments were corporately recorded and shared. Barnsley general community services identify most compliments (in part due to the nature of the service). Work is on-going to encourage all services to share compliments received;<br>➢ 265 requests for information under Freedom of Information Act were processed.<br><br>The team continues to work with teams and services to support a positive response to feedback, and to review this from both the perspective of the service user and from that of staff.<br><br>All Trust services have processes in place to collect Friends and Family Test feedback. Results in March 2016 showed that 71% of people would recommend mental health services and 99% would recommend general community services. The least positive scores recorded were in child and adolescent mental health service (long waiting times, which are being addressed through service redesign) and Forensic services (not automatically viewed as a service of choice).<br><br>Work also began in 2015/16 to prepare for the Trust assessment for re-accreditation against the Customer Services Excellence Standard, which recognises positive practice in understanding people who use an organisation's services and meeting their needs. The 'on-site' element of the assessment concluded on 10 June 2016 and early feedback has been positive. The final report is still subject to quality control by the Centre for Assessment, and formal notification is anticipated in late July/early August 2016. An action plan will be developed when the accreditation report is received, which will be aligned to the |

| | |
|---|---|
| | Care Quality Commission action plan to ensure common themes are picked up and to prevent unnecessary duplication. |
| **Recommendation:** | **Trust Board is asked to NOTE the management of issues raised through Customer Services in 2015/16 and to NOTE this in the broader context of other work in relation to understanding service user experience.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership
NHS Foundation Trust

# Customer Services – Annual Report - 2015 - 16

## Introduction

This report provides an overview of feedback received by the organisation through the Customer services function in the financial year 2015 - 16.
The report covers all feedback received by the team – comments, compliments, concerns and complaints, which are managed in accordance with policy approved by the Trust Board. There is a customer focus KPI with a target that less than 25% of complaints should include staff attitude as a component. This is monitored by Trust Board through monthly performance reports. In 2015 -16, the target was met with average performance of 14%.

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

This report includes:

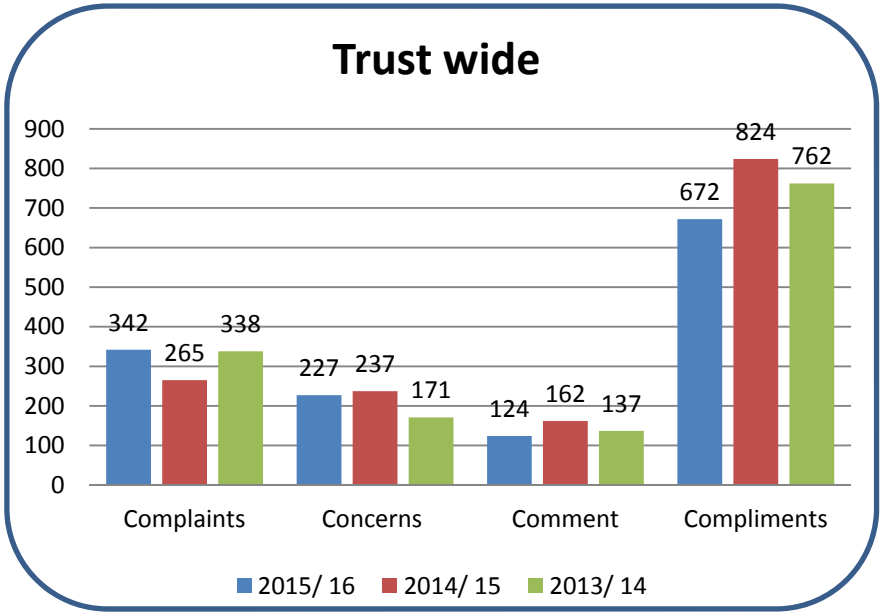
- the number of issues raised and the themes arising, and Friends and Family Test results
- equality data
- external scrutiny and partnering
- Customer Services standards including response timeframes
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received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

## Feedback received

The number of formal complaints received in the year was 342; this is an increase on the previous year when 265 complaints were received, and is in line with 2013 /14 when 338 complaints were recorded. There was a decrease in the year in the number of issues resolved at service level.

Communication was identified as the most frequently raised negative issue (95). This was followed by values and behaviours (staff) (90), patient care (64), access to treatment and drugs (59), Trust admin / policies / procedures (58), waiting times (39), and appointments (39). Most complaints contained a number of themes. Actions taken and lessons learnt are shared across BDU's, summaries provided at p12-p15).

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



## Contact

The Customer Services Team processed just under 600 general enquiries in the last year, in addition to '4 Cs' management. Consistent with past reporting, signposting to Trust services was the most frequently requested advice. Other enquiries included requests for information about Trust Services, providing contact details for staff and information on how to access healthcare records. The team also responded to over 1500 telephone enquiries from staff, offering support and advice in resolving concerns at local level . This was a significant increase in staff contact compared to the previous year.

## Informal Issues

During the year, Trust services responded to 351 issues of concern and comments at local level compared to 399 the previous year. The Customer Services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right as and when they happen wherever possible and supports shared learning about service user and carer experience.

## CQC / ICO

The Trust had one complaint referred by the CQC (in Qtr. 3). This related to Wakefield Older People In-patient Services, regarding detention under the Mental Health Act, capacity and access to finances. This is now resolved through provision of additional explanation.

Following a complaint, the Information Commissioner is currently reviewing a report prepared by the Trust regarding an information governance breach in Kirklees CAMHS (confidential information sent to incorrect address) .

## Mental Health Act (MHA)

19 complainants raised concerns with the Trust in 2015/16 regarding detention under the Mental Health Act. 12 individuals chose not to specify their ethnicity, 6 described themselves as white British, and 1 as mixed race.

Information on the numbers of complaints regarding application of the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

## PHSO

At the start of the financial year, 5 cases were with the Parliamentary and Health Service Ombudsman (PHSO) for consideration. In 2015-16, 17 complainants asked the PHSO to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. Information requested by the Ombudsman in relation to the above was provided within the prescribed timeframe.

During 2015-16, the Trust received feedback from the Ombudsman regarding 16 cases. 13 were closed with no further action required. 2 cases (both Wakefield, Adult Services) were reviewed and upheld. 1 case (Kirklees, Acute Inpatients – adult) was subject to review and partially upheld. Action plans for these 3 cases have subsequently been completed, with learning including improved discharge planning, review of referral protocols and ensuring the reasons for not accepting referrals is clearly communicated.

The Trust currently has 5 cases pending with the Ombudsman. It can take a number of months before the Ombudsman is in a position to advise the Trust on its decisions (due to the volume of referrals received by PHSO).

## NHS Choices

The Trust has introduced measures to attempt to drive traffic to NHS Choices, in recognition that this site is an external source of information about the Trust. Survey materials promote NHS Choices as an additional means to offer feedback about the Trust and its services. The website is monitored to ensure timely response to posted feedback.

During 2015/16, 7 individuals added comments on NHS Choices about their experience of Trust services, which were acknowledged, and shared with teams where possible.

4 compliments were received, one for Trinity 1, and 1 for Trinity 2 in Wakefield. Services were not named In the other 2 compliments posted.

3 complaints were posted, 1 regarding Elmfield House. We were unable to identify which service the other 2 complaints were in relation to. Individuals posting comments are requested to make direct contact with the Trust , to support resolution of issues.

| Issues spanning more than one organisation 2015 / 16 | Complaint | Concern | Comment |
|---|---|---|---|
| Barnsley Hospital NHS Foundation Trust | 3 | 0 | 0 |
| Barnsley Metropolitan Borough Council | 1 | 2 | 1 |
| Calderdale and Huddersfield NHS Foundation NHS Trust | 1 | 1 | 0 |
| Care Quality Commission | 3 | 1 | 0 |
| Harrogate and District Foundation NHS Trust | 0 | 1 | 0 |
| Kirklees Council | 1 | 0 | 0 |
| Mid Yorkshire Hospital NHS Trust | 1 | 0 | 0 |
| NHS Barnsley | 1 | 0 | 0 |
| NHS Barnsley CCG | 0 | 0 | 1 |
| NHS Bassetlaw CCG | 0 | 1 | 0 |
| NHS Calderdale CCG | 1 | 0 | 1 |
| NHS England | 1 | 0 | 0 |
| NHS Greater Huddersfield CCG | 1 | 0 | 0 |
| NHS Wakefield CCG | 1 | 2 | 0 |
| Other | 1 | 0 | 0 |
| Other Local Authority | 1 | 1 | 0 |
| Sheffield Teaching Hospital | 0 | 1 | 0 |
| Wakefield Metropolitan District Council | 1 | 0 | 0 |
| Issues raised by Members of Parliament (MPs) | 23 | 10 | 21 |

## Joint Working

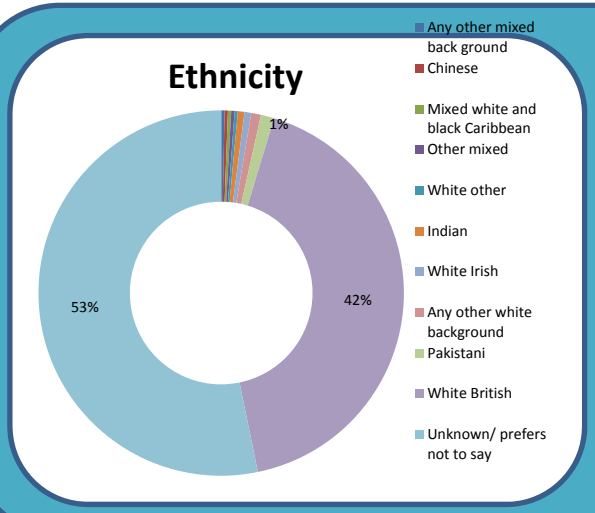
National guidance emphasises the importance of organisations working together where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

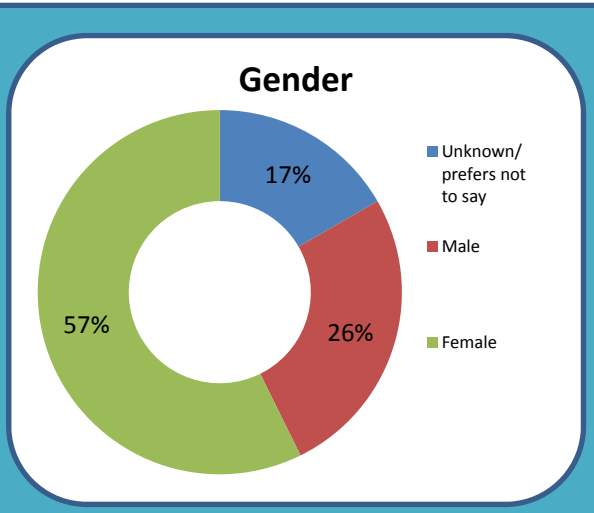
Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

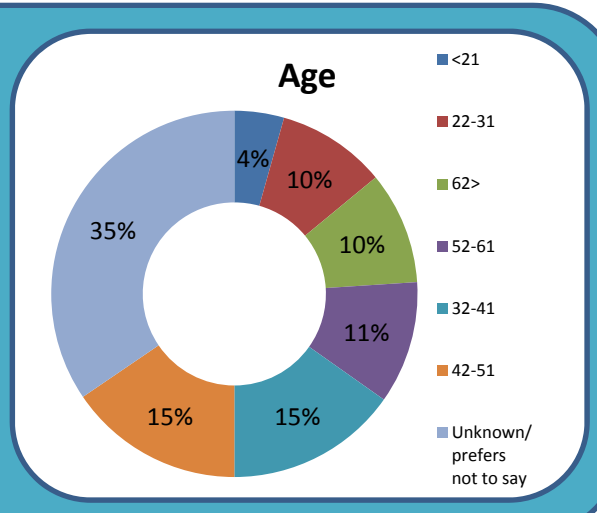
The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and request additional information from the Trust on occasion.

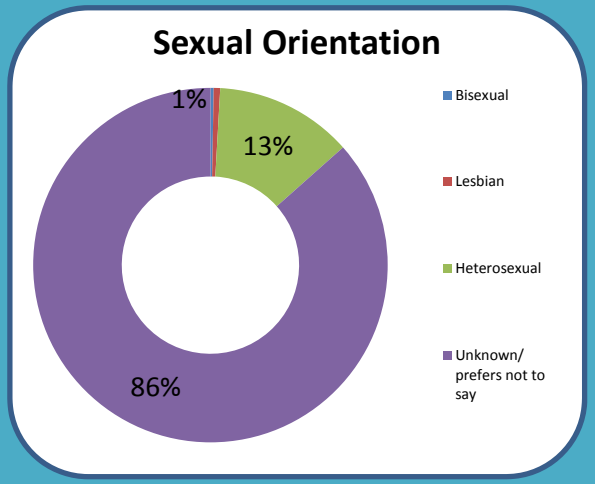
Healthwatch are encouraging local people to share their experience of health services via their websites and will theme and share feedback as data is collected and collated.

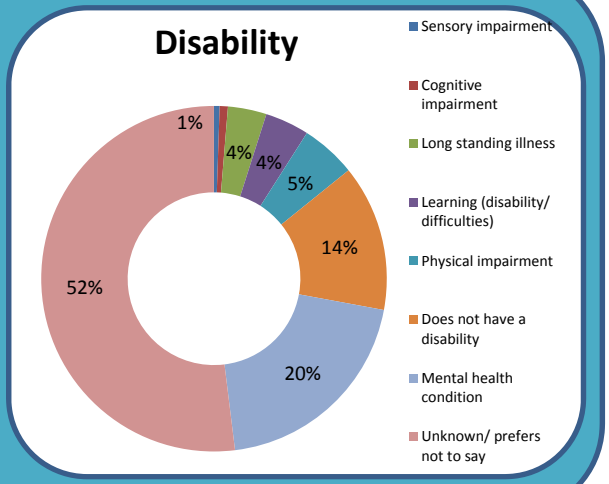
# Equality and Inclusion – Formal Complaints - Protected Characteristics Data



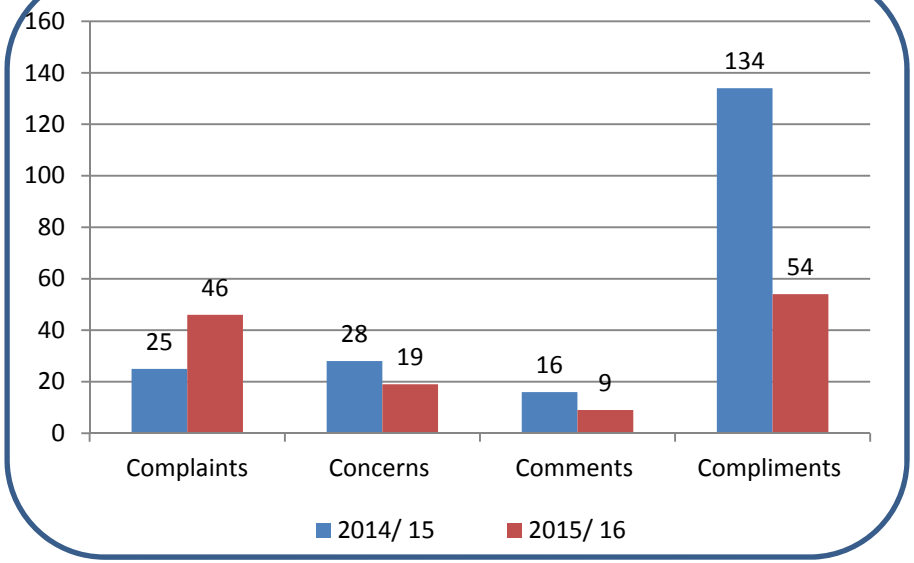

The charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. This is collated Trust- wide.

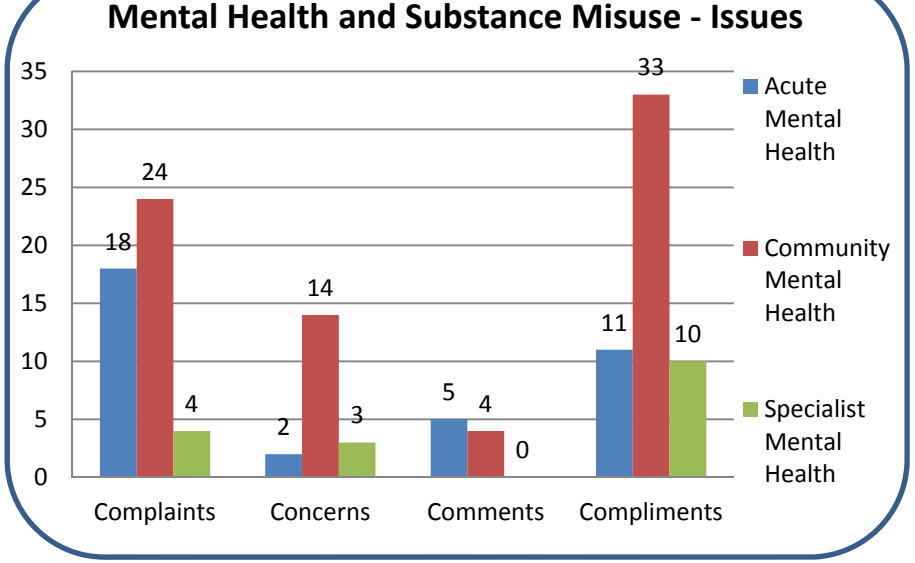
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. To support improvement in the number of forms returned / completed, additional information is now also shared explaining why collection of this data is important to the Trust and that it is essential to ensure equality of access to Trust services.

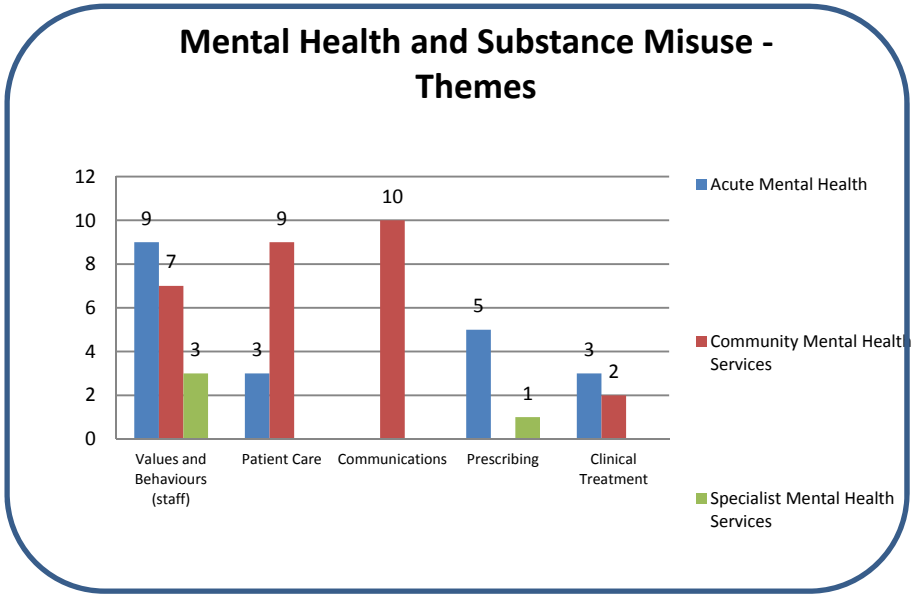
The Team continues to explore best practice in data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

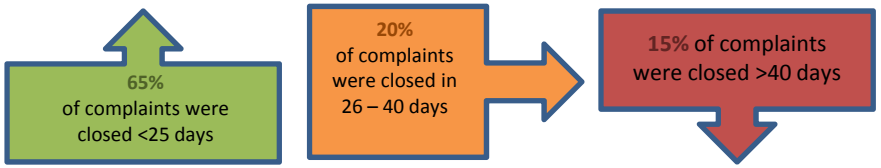
# Barnsley Business Delivery Unit – mental health & substance misuse

## Number of issues



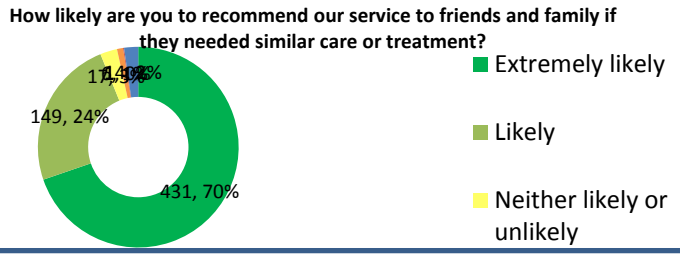



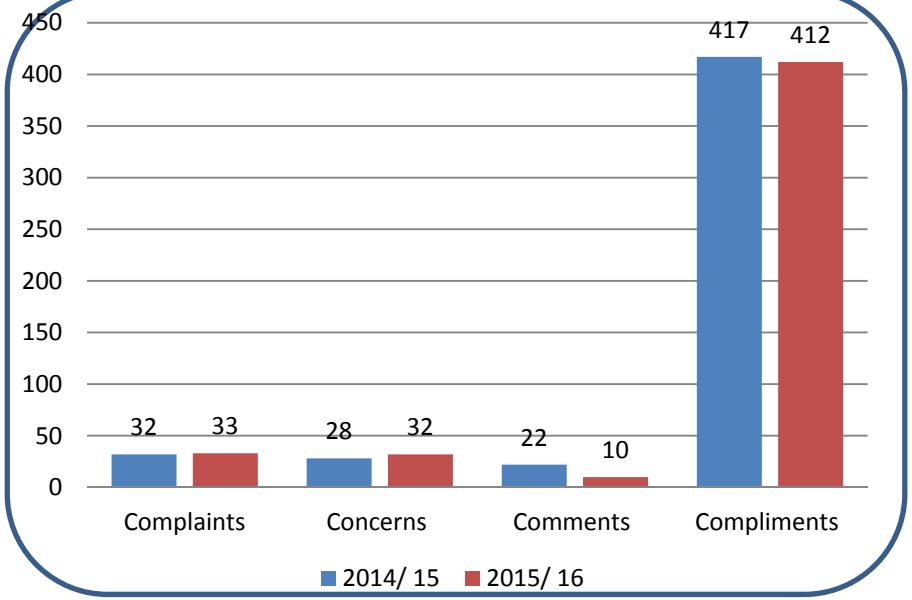

Complaints closed over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases.

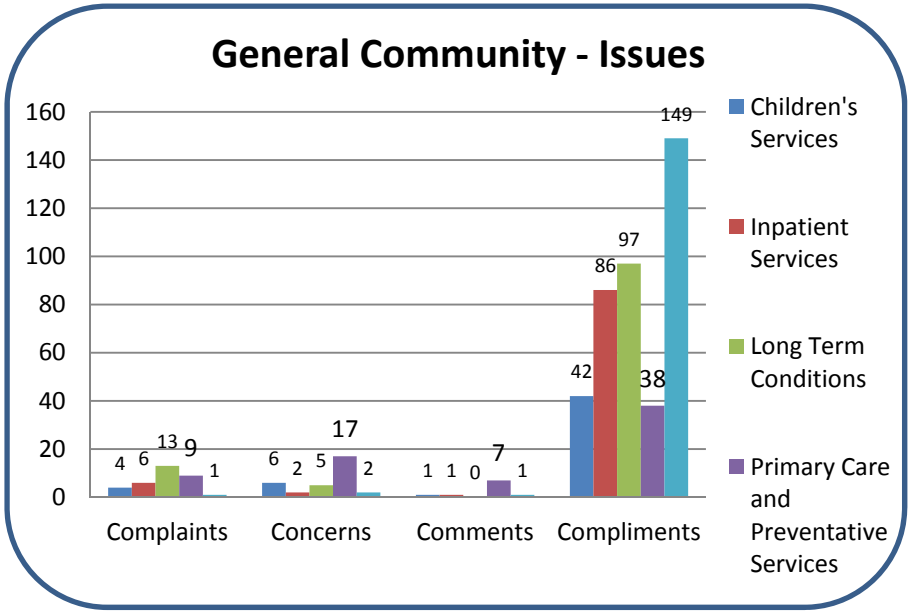
## Friends and Family Test

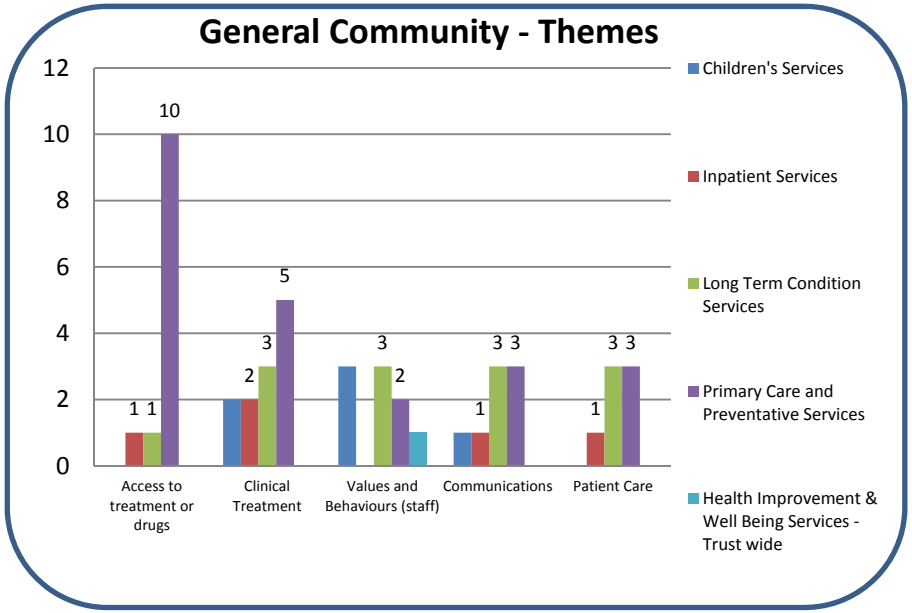


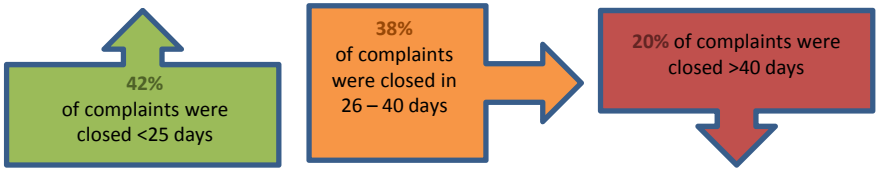
# Barnsley Business Delivery Unit – general community services

## Number of issues



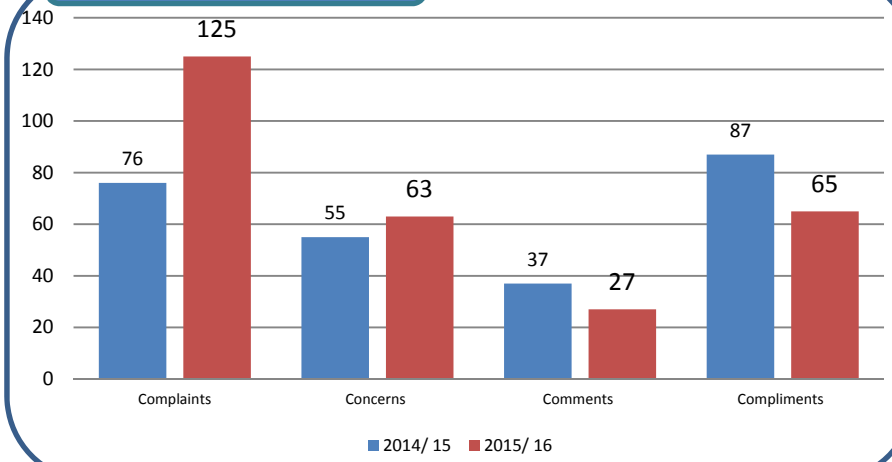



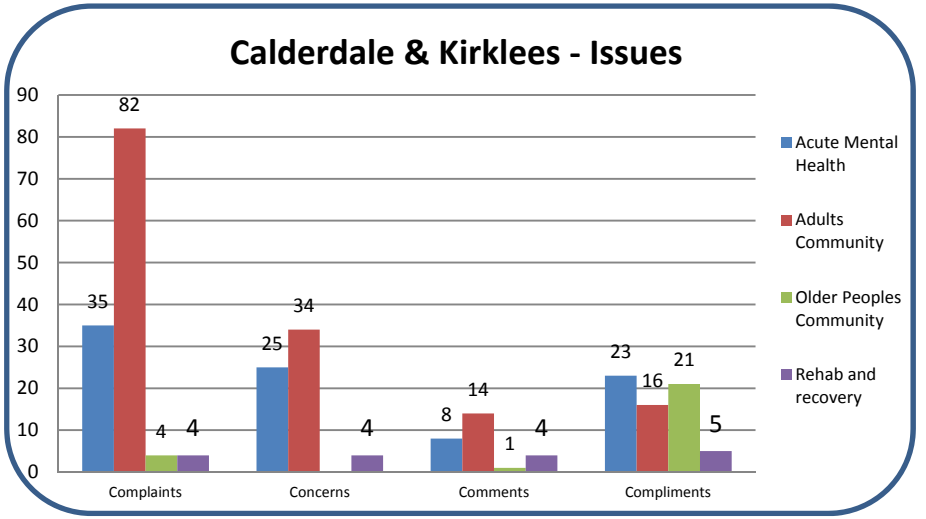

Complaints closed over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases.

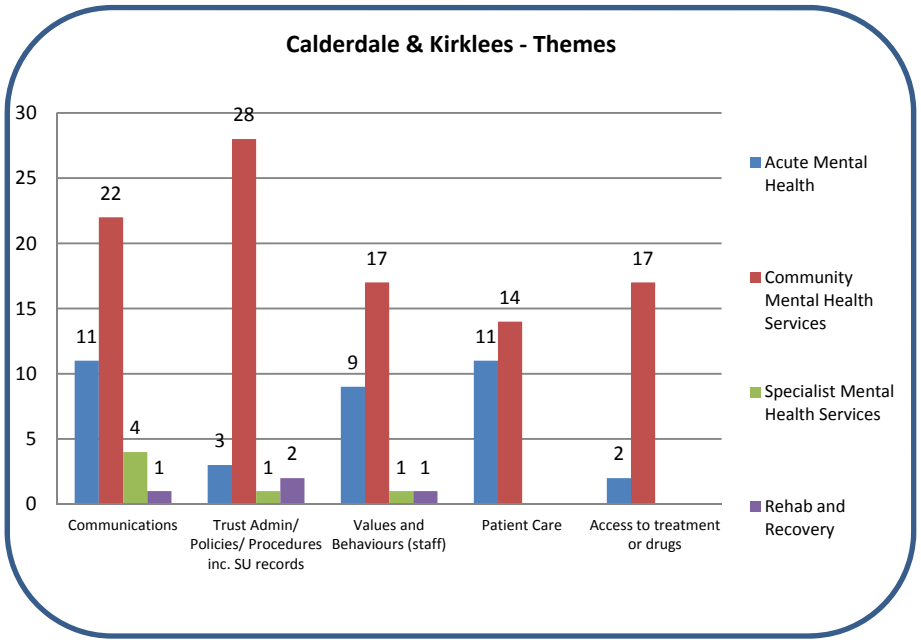
## Friends and Family Test

# Calderdale & Kirklees Business Delivery Unit

## Number of issues



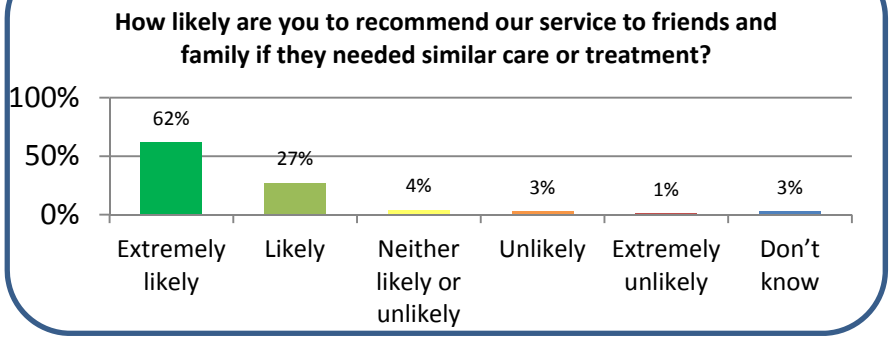

**52%** of complaints were closed <25 days

**27%** of complaints were closed in 26 – 40 days

**21%** of complaints were closed >40 days

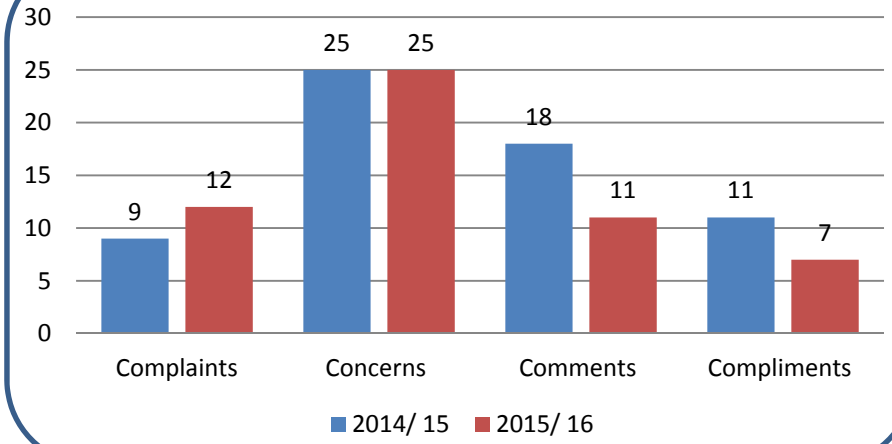
Complaints taking over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. During Qtr 4 64% of complaints were closed within 25 days.

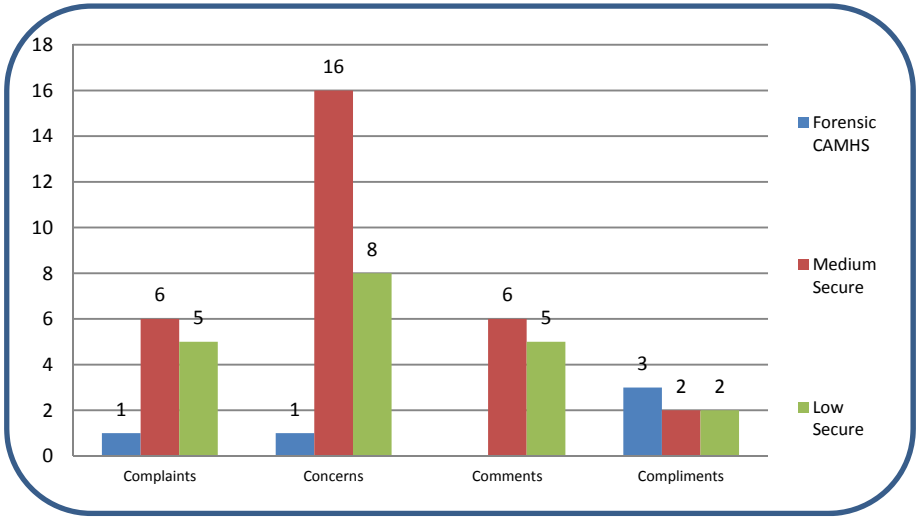
## Friends and Family Test

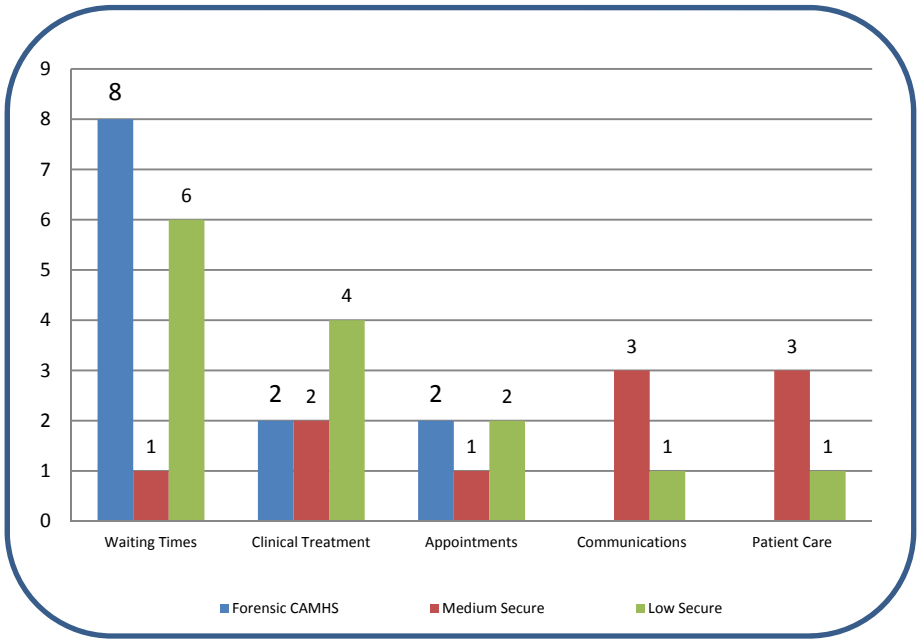


# Forensics Business Delivery Unit

## Number of issues




**50%** of complaints were closed <25 days

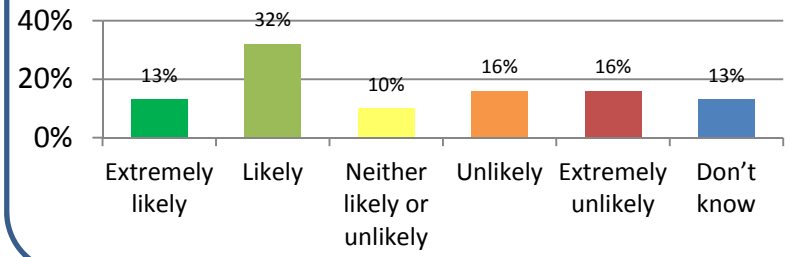
**25%** of complaints were closed in 26 – 40 days

**25%** of complaints were closed >40 days

Complaints closed over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases.

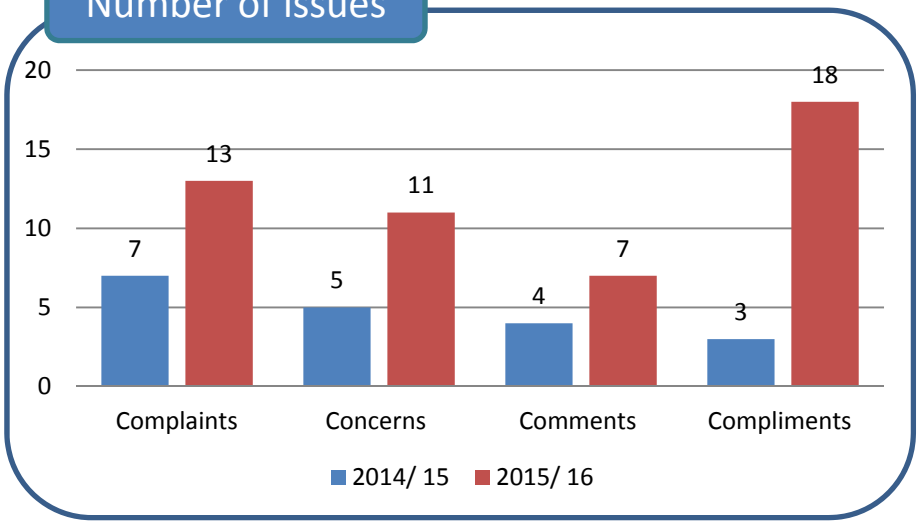
## Friends and Family Test

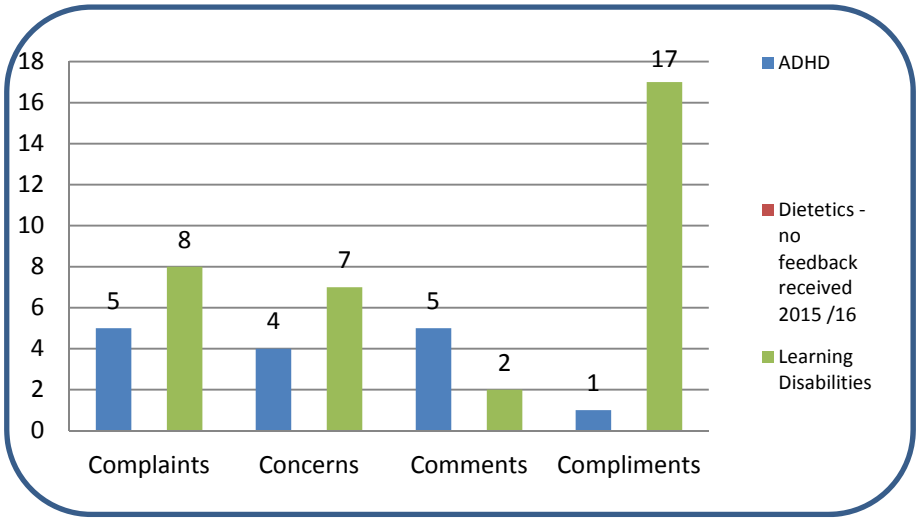
**How likely are you to recommend our service to friends and family if they needed similar care or treatment?**

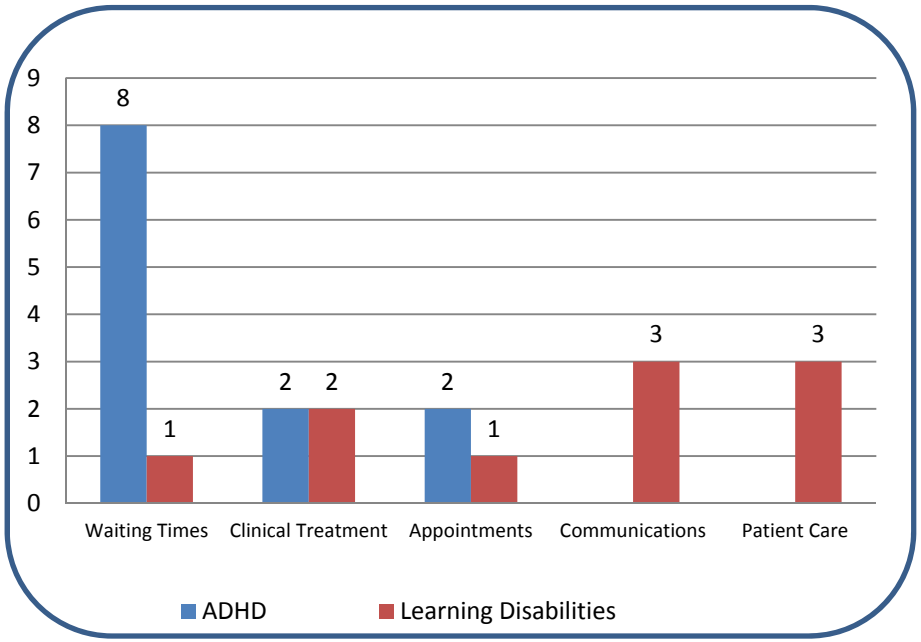


# Specialist Services Business Delivery Unit (excluding CAMHS)

## Number of issues



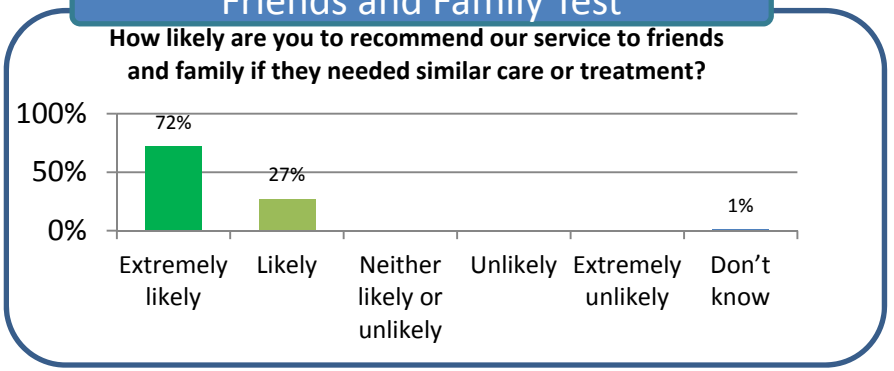

56% of complaints were closed <25 days

0% of complaints were closed in 26 – 40 days

45% of complaints were closed >40 days

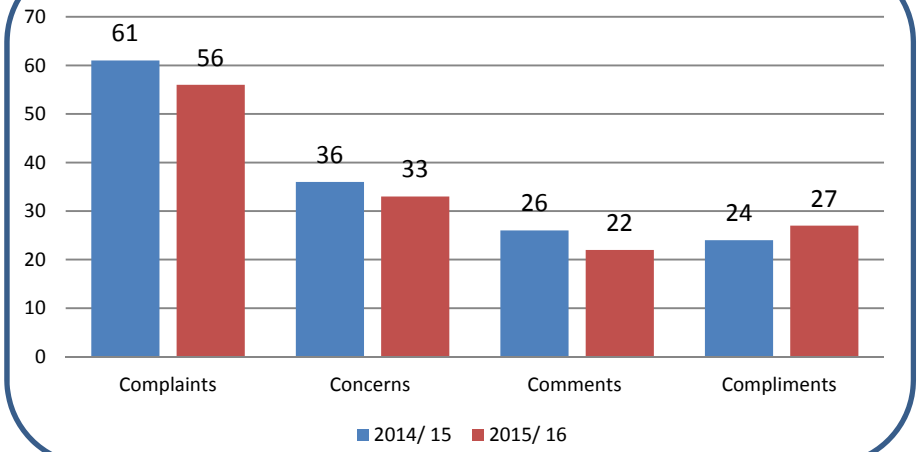
Complaints taking over 40 days to close were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. In Qtr 4, 100% of cases closed within 25 days.

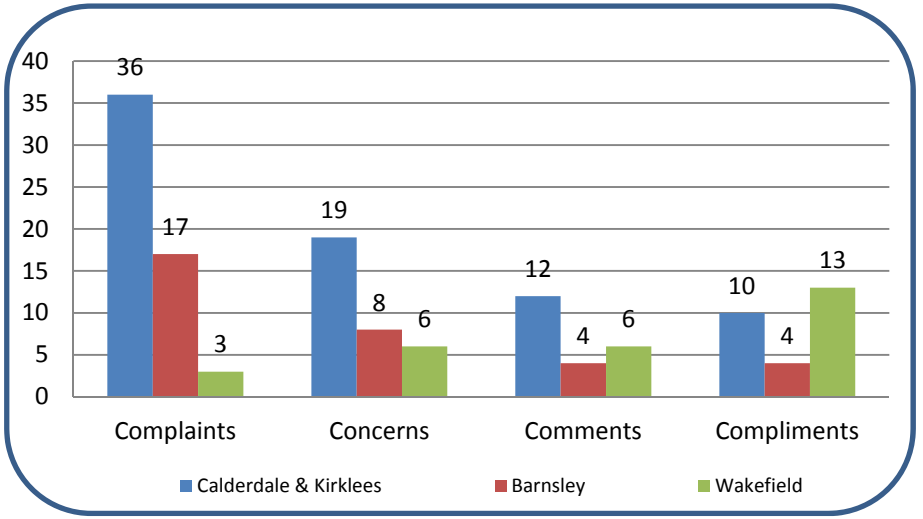
## Friends and Family Test

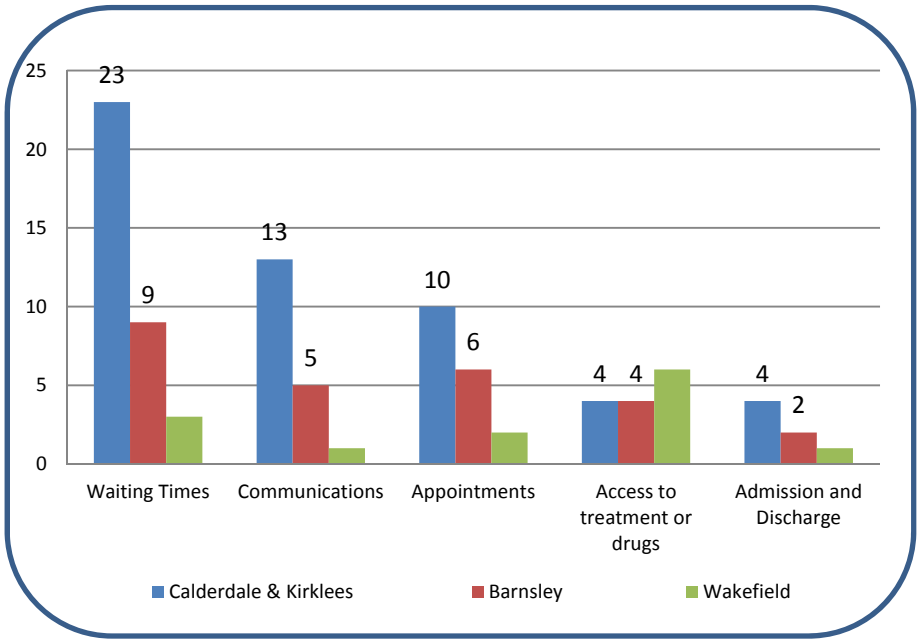


# Child and Adolescent Mental Health Services

## Number of issues



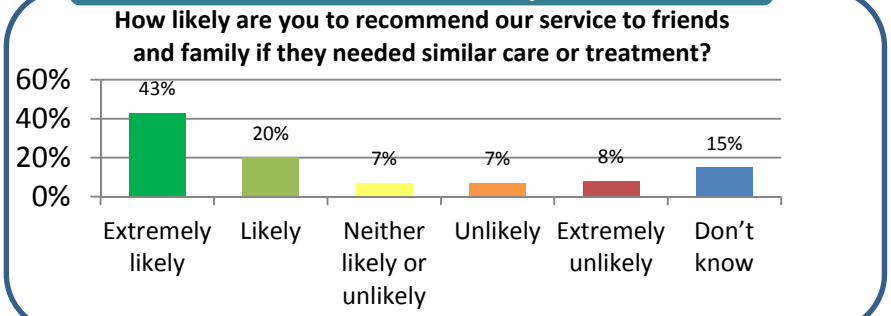

**40%** of complaints were closed <25 days

**18%** of complaints were closed in 26 – 40 days

**36%** of complaints were closed >40 days

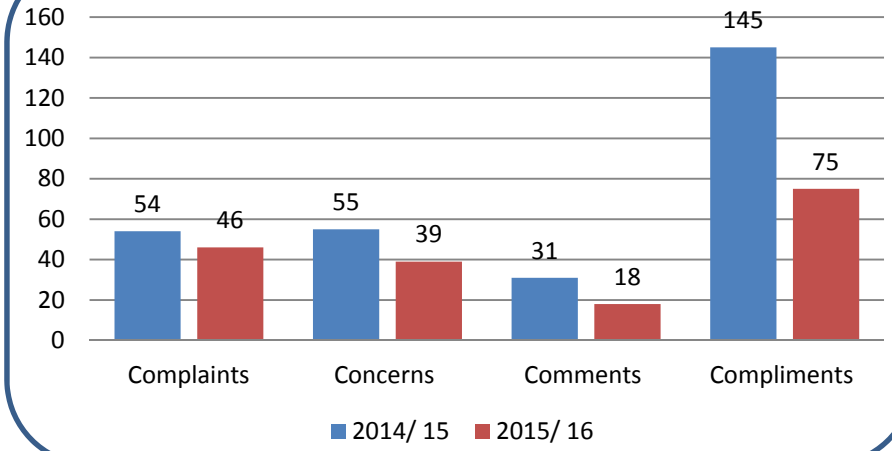
Complaints taking over 40 days to close were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. In Qtr 4, 64% of cases were closed within 25 days.

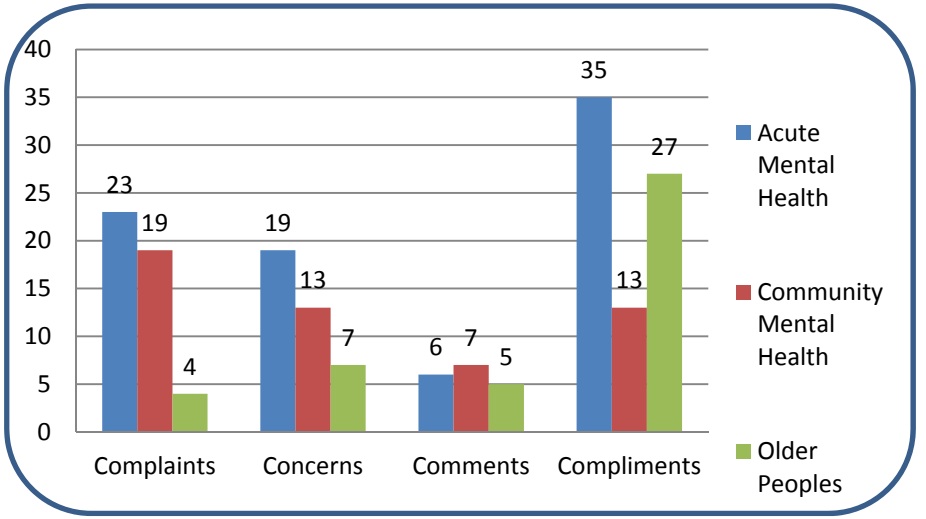
## Friends and Family Test

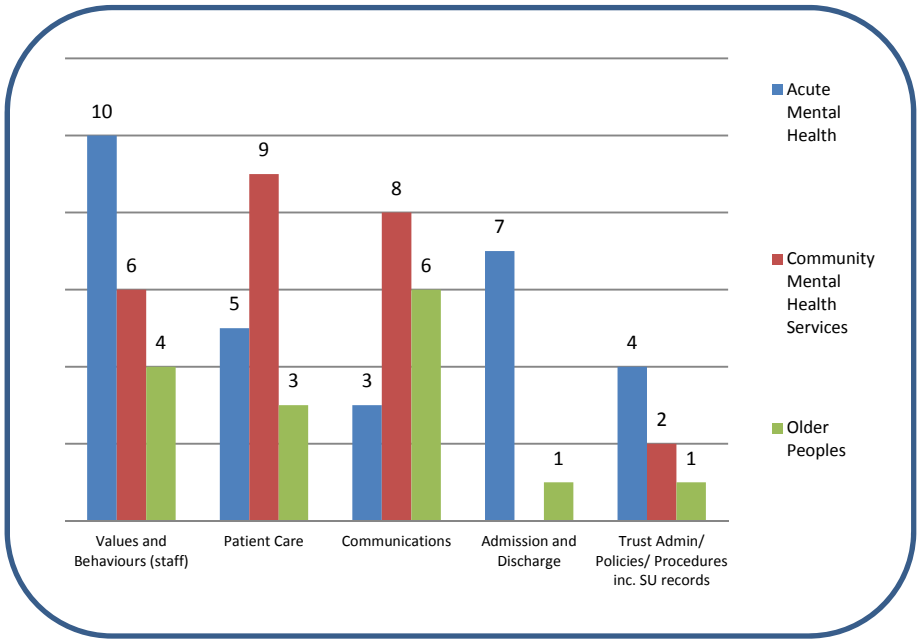


# Wakefield Business Delivery Unit

## Number of issues




**44%** of complaints were closed <25 days

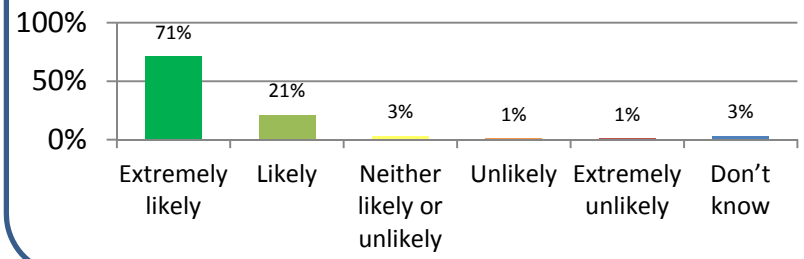
**18%** of complaints were closed in 26 – 40 days

**38%** of complaints were closed >40 days

Complaints taking over 40 days to close were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. In Qtr 4, 50 % of cases were closed within 25 days, and a further 30% within 40 days.

## Friends and Family Test

**How likely are you to recommend our service to friends and family if they needed similar care or treatment?**



## Actions Taken

# Barnsley

## General Community Services

To review communication with families, particularly in circumstances when multiple services/organisations are involved. – ***0-19 Children's Universal Services, Central***

To ensure that clinical supervision supports case reviews as a learning vehicle for staff. This will include the need to maintain positive working relationships, perception of staff attitude by service users and families and the need to keep families fully informed of changes to care. – ***District Nurses Locality 1***

To improve communication with family/carers. – ***District Nurses Locality 2***

To review incident to ensure wider learning. – ***District Nurses Locality 3***

To improve communication with carers regarding safeguarding issues - ***District Nursing Locality 4***

To ensure effective communication with families - ***Children's Speech and Language Therapist Service***

To improve process in relation to managing, reviewing and sharing referral criteria across organisations. To also follow up appointment letters with telephone contact with service users to encourage attendance - ***COPD Team***

To check understanding of prescribed medication to support informed decisions and to reinforce medication administration procedures with staff - ***Ward 4***

To improve communications with service users and carers. – ***Ward 4***

To ensure good record keeping practices are in place – ***Ward 4***

## Barnsley Mental Health and Substance Misuse

To ensure appropriate checks are undertaken with carers / families prior to discharge in relation to medication and accommodation needs. – ***Beamshaw Ward***

To review process of inter ward transfers to ensure they are effective and efficient – ***Beamshaw Ward***

To produce an information booklet for carers on the side effects of anti-psychotic medication. – ***Beamshaw Ward***

To ensure all restraints are reviewed and documented in service user progress notes (RiO) – ***Clark Ward***

To introduce an 'Opt In' letter for service users on the waiting list to ensure service still required – ***CMHT Central***

To acknowledge all correspondence from family/ carers, and respond appropriately taking account of consent issues - ***CMHT Central***

To promote improved communication between service users and staff – ***CMHT Central***

To review individual care plan and update as clinically appropriate – ***CMHT North***

To ensure that service users are made aware of any planned/ proposed changes to care, ensuring that this is communicated in a timely manner. – ***CMHT North***

To ensure that service user's family/ carers are fully informed about decisions relating to care, and the reason for any decisions/ changes. – ***CMHT North***

To improve communication so that service user feels listened to, and involved in their care/ decisions about care. – ***CMHT North***

To ensure that a full explanation and apology is provided for any cancelled appointment and to ensure that service users are informed about different routes/ ways to access services – ***Memory Service***

To ensure clear communication with service users and carers regarding assessment processes – ***IAPT***

To improve communication between service user and carers – ***IAPT***

To ensure that information regarding alternative services is provided and that the purpose of assessment is explained and questions answered - ***SPA***

## Actions Taken

### Calderdale & Kirklees

To provide written information about medication to service users, particularly when there are medication changes. – ***AOT Calderdale***
To support service users to understand the service offered by primary care and that offered by the Trust to avoid confusion. – ***Assessment and Intensive Home Based Treatment Team / Crisis Team***
To ensure the professional guide for pharmacists is followed when prescribing controlled drugs, and that up to date service user information on prescriptions is offered – ***Calderdale Alcohol Team***
To monitor staff behaviour and support any identified training in relation to communication skills - ***CMHT – Calder Valley***
To ensure staff review is available to support learning - ***Calder Valley***
To allocate a dedicated support worker. – ***CMHT - Lower Valley***
To ensure staffing issues do not negatively impact service quality / consistency, and that the reason for decisions is clearly explained to service user – ***CMHT - Lower Valley***
To ensure that relative's details are captured on clinical record wherever possible. Where relative cannot be contacted re SUI process, coroner to be informed. – ***CMHT - Lower Valley***
To introduce procedures to ensure that the inpatient consultant orders medication prior to discharge. – ***CMHT - Lower Valley***
To ensure service user information remains confidential - ***Elmdale Ward***
To ensure that reasons for delay regarding appointments are clearly communicated to service users. To work in partnership with commissioners to ensure that resources are available to ensure that waiting times are reduced - ***IAPT, Calderdale***
To alert clinical staff to messages in a timely fashion – via text message or email - **IAPT, Calderdale**
To improve communication with service user and family ***– Intensive Support Team – Calderdale***
To ensure service users have a contact point to discuss reports received or the opportunity to meet with clinician alone following a joint appointment. – ***Psychological Therapies***, ***Calderdale***
To ensure ward facilities are clean and rooms vacated appropriately – ***Ashdale Ward***
To ensure clear communication with service users and carers – ***Ashdale Ward***
To ensure communication with service users is not impacted when staff changes are necessary – ***CMHT North Kirklees***
To ensure clinical decisions are explained and documentation processed in a timely manner – ***CMHT Care Management Team, Kirklees***
To review current appointment letters to ensure full information is provided about review processes in clinic – ***CMHT Care Management Team, Kirklees***
To communicate more effectively and explain actions to all parties involved – ***CMHT Care Management Team, Kirklees***
To improve communication with service users regarding care plans/medication options – ***CMHT Care Management Team, Kirklees***
To ensure service users are informed of alternative packages of support available outside of normal working hours in case of a relapse in mental health – ***CMHT - Community Therapies Team, Kirklees***
To ensure correct procedures are followed for referral between teams within the Trust, and ensure clear communication with service user where there is a delay or problem with referral between teams – ***CMHT - Community Therapies Team, Kirklees***
To ensure that advocacy details are available and easily accessible within each service – ***IAPT, Kirklees***
To review administrative arrangements for therapy appointments, to ensure cancelled appointments are kept to a minimum – ***IAPT, Kirklees***
To ensure service users understand the circumstances in which information would be shared with GP and other healthcare professionals – ***IAPT, Kirklees***
To ensure contact is maintained with individuals who are waiting to attend a course – ***Psychological Therapies, Kirklees***
To improve record keeping (including up to date information discussed and provided to service user and family). Written information to be provided following discussions with service user and family. – ***Ward 19***
To ensure that conditions of detention are fully explained to the nearest relative – ***Ward 19***

## Actions Taken

### Specialist Services

To explain the service constraints to manage expectations – ***ADHD Services***
To ensure understanding of the pathway of care regarding episodes of crisis, specifically for people with learning disabilities – ***Calderdale Community Learning Disability Team***
To ensure that, in circumstances where prescribing is outside the Trust guidance or advice, a full explanation is provided to service user, carers and family where appropriate – Fox view

### CAMHS

To ensure that good communication is maintained with family/ individual, and that the reasons for clinical decisions are clearly explained – ***Wakefield***
To ensure the correct administration process is actioned in a timely manner following referral – ***Calderdale***
To improve contact with service users, carers and external agencies – ***Calderdale***
To review the pathway for therapies – ***Calderdale***
To review ways of working with commissioners – ***Calderdale***
To review content of CAMHS assessments, and how information is delivered to families - ***Calderdale***
To review the way workload is covered when staff members are away from work. Team to also ensure that letters are sent following allocation to waiting list for assessment / or discharge – ***Kirklees***
To ensure efficient management of cases when a staff member is away from work, ensuring that all cases are re allocated where necessary – ***Kirklees***
To ensure clear communication with families regarding the roles of different organisations involved in a child's care, where there is a multi-agency approach, and that a full explanation is provided where there are changes to care/ treatment – ***Kirklees***
To ensure that cases are allocated when staff are absent long term, that communication is maintained with families and other health professionals, and appropriate contact details are provided to families – ***Kirklees***
To ensure that service users are informed of cancelled appointments in a timely manner – ***Kirklees***
To ensure that children and young people, and their families, feel involved in their care and treatment, and ensuring all urgent calls are returned in a timely manner – ***Kirklees***
To improve communication and efficiency between different parts of the multi-agency team, ensuring that information provided the service users/ families is factually accurate – ***Kirklees***
To provide training on screening referrals to ensure that these are based on the locality of the GP. – ***Kirklees***
To improve communication between service and service user – ***Barnsley***
To clearly communicate actions and processes – ***Barnsley***
To ensure that families know how to contact the team in an urgent/ crisis situation – ***Barnsley***
To ensure that cancelled appointments are effectively notified - ***Barnsley***
To improve record keeping – ***Barnsley***
To ensure clear explanations of clinical decisions are provided and to manage service capacity more effectively – ***Barnsley***

## Actions Taken

### Forensics

To review administrative support required to prevent unnecessary delays in processing paperwork – ***Appleton***
To ensure that security and vigilance is increased in light of illicit substances being smuggled onto ward – ***Hepworth Ward***
To implement measures to ensure that service users receive all documentation prior to their tribunal. To ensure improved communication with carers/family members regarding unescorted leave - ***Hepworth Ward***
To ensure that the service user feels fully involved in decisions about their treatment, and that their opinion is considered when making decisions about medication – ***Johnson Ward***
To encourage a service user to explore his thoughts and feelings through ongoing psychology sessions, and to discuss how care is progressing and any difficulties being experienced - ***Newhaven Forensic Learning Disabilities Unit***
To ensure records are reviewed in advance of appointments / meetings – ***Ryburn Ward***
To ensure guidance is provided to service users on admission and discharge checklist on transferring money – Sandal Ward

### Wakefield

To improve communication with service user and carer – ***APTS***
To ensure a consistent approach regarding the use of flowers on the ward - ***Chantry Unit***
To ensure clear communication exists between all health professionals involved in care, ensuring reasons for clinical decisions are fully explained – ***CMHT 3***
To ensure healthcare records reflect cancelled appointments and reason for cancellation - ***CMHT 3***
To ensure that practitioners adhere to principles of good, clear communication, including being mindful of audience, moderating tone and volume of speech and remaining sensitive to different cultural perceptions of communication – ***CMHT 4***
To review current service leaflet to include circumstances when information may be shared with other professionals/partner organisations – ***Crisis Team***
To ensure assessment processes are fully explained and questions answered - ***Crisis Team***
To ensure team diary is appropriately updated - ***Crisis Team***
To ensure clear explanation of service remit - ***Crisis Team***
To ensure clear communication regarding transfer of care between teams – ***Early intervention Team – Insight***
To ensure paperwork issued by the service is checked to prevent errors – ***Memory Service***
To provide opportunities for carers to discuss concerns in a private space - ***Memory Services***
To ensure clinical decisions are clearly explained and that the process is followed with regard to arranging periods of home leave – ***Priory 2***
To ensure support line contact details are provided in appropriate cases – ***Priory 2***
To review the pathway for transfers between psychiatric intensive care units and acute wards and to improve communication between staff and carers through additional training – Trinity 2

# Freedom of Information requests

265 requests to access information under the Freedom of Information Act were processed in 2015/ 16, an increase on the previous year when 226 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

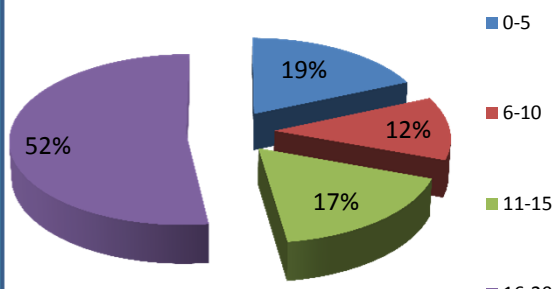
The Customer Services Team works with information owners in the Trust to respond to requests as promptly as possible, but within the 20 working day requirement.

During the year, 5 exemptions were applied –

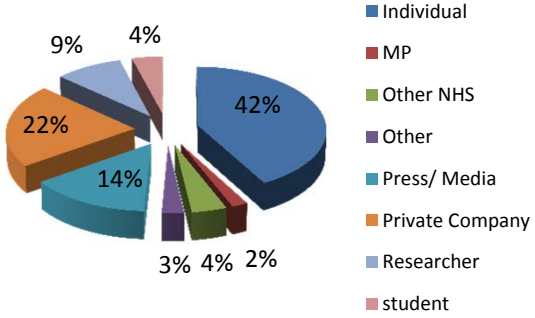
- 2 under section 41 - public sector contracts,
- 2 under section 43 - commercial interests
- 1 under section 40 - personal information.

There was one appeal against a decision made in respect of management of requests under the Act during the year. The decision to apply a section 41 exemption (Information provided in confidence) was upheld by the Trust.

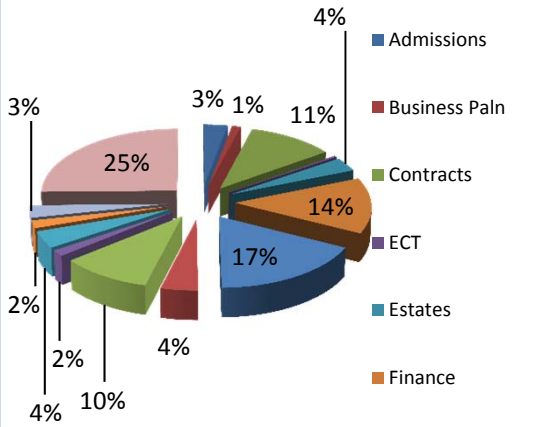
## Number of days to respond




## Origin of request




## Types of request



# Trust Board 28 June 2016
# Agenda item 6.3(iv)

| | |
|---|---|
| **Title:** | **Safety Management and Contingency Planning Annual Report** |
| **Paper prepared by:** | Director of Human Resources and Workforce Development |
| **Purpose:** | Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and, as far as is reasonably possible, risks are mitigated or reduced. This paper is devised to give assurance on the ongoing management of safety management and contingency planning. |
| **Mission/values:** | Safety and effectiveness in a complex environment is vital to ensuring individuals receive care that enables them to live well in their communities. |
| **Any background papers/ previously considered by:** | The Clinical Governance and Clinical Safety Committee receives regular updates based on exception reporting. |
| **Executive summary:** | The Safety Management and Contingency Planning report for 2015/16 is designed to give an overview of the leadership and management of both safety management and contingency planning. In summary, the attached annual report gives an update on:<br>➢ the structure within the Trust for the management and engagement of key stakeholders in safety management and contingency planning;<br>➢ the creation of a Director on-call process and the implementation of an on-call pack;<br>➢ the monitoring and auditing of health and safety in the workplace and action taken;<br>➢ key health and safety risks and action to mitigate them;<br>➢ health and safety training activity;<br>➢ the Trust's response to changes in legislation;<br>➢ an overview of incidents during 2015/16;<br>➢ an update on 2014/15 objectives.<br>The 2016/17 action plans build on the previous years and is designed to:<br>➢ continue to embed a robust risk-based approach, monitoring and audit programme;<br>➢ refine a set of key performance indicators to help manage risk and improve safety and emergency planning arrangements in the Trust;<br>➢ continue to improve access to training. |
| **Recommendation:** | **Trust Board is asked to APPROVE the Safety Management and Contingency Planning Annual Report and AGREE the action plans for 2016/17.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Annual Safety Services Report 2015/16

Trust Board 28 June 2016

With **all of us** in mind.

# Contents



# Appendices

# Safety Services Annual Report 2015/2016

## BACKGROUND

Over previous years, separate annual reports have been developed from each branch of Safety Services. The reports received were from Health & Safety, Fire Safety, Security and Emergency Planning. This report is designed to provide an overview of the key achievements from all respective areas during 2015/2016, and any areas of development within 2016/2017. Areas of development will be provided by way of action plans and added as appendices to this document.

## INTRODUCTION

The following annual report provides Trust Board with an up to date summary on Trust current activities relating to Safety Services for the reporting period of 2015/2016.

All teams have worked throughout the year to achieve both internal targets and external targets and legislation, for instance, the NHS Protect Security Standards, Fire Safety Legislation, Mandatory Training targets and the Care Quality Commission (CQC) standards, to name a few. Details of such achievements will be referenced throughout the report.

## TRAINING

The respective teams deliver a variety of training packages across the Trust; these packages are both mandatory and essential. Those training packages and achievement against their respective targets are noted below:

*Fire Safety Training:*

86.7% of Trust staff attended fire training sessions or completed e-learning during the financial year, which exceeds the Board implemented target of 80%.

This achievement is worth note, given that initial fire training is no longer included on the Trust induction. In order to maintain such a level of provision, the fire safety team provided 446 physical fire training sessions. 2000 staff members also completed the Trust e-learning Fire Safety package.

*Health & Safety Related Training:*

Overall the number of participants undertaking Safety related training during 2015/2016 numbered 4279. Safety related training, in this context excludes additional training provided by the Fire, Security, Managing Aggression and Violence (MAV), and Infection, Prevention and Control teams. (See Appendix 1 for a breakdown of numbers and respective courses attended).

All of the training courses noted in the table are essential, with the exception of Moving and Handling training, which is mandatory with a target to train 80% of Trust staff throughout the financial period. The combined figure for all mandatory Moving and Handling training is 85.6%, an increase of 15.5% from the previous year.

The figures can be broken down further to 87.75% of staff completing the basic mandatory training requirement either by e-learning or completing the workbook. Practical part 2 People Handling has risen to 77.15%

*Security Training:*

A total of 321 staff members were provided with Conflict Resolution training during the financial year, 205 completed e-learning and 116 attended a face to face training session.

This is a reduction on previous years; however analysis shows that this is due to the training no longer being graded as Mandatory.

*Emergency Planning Training:*
A Training Needs Analysis (TNA) was undertaken in the first quarter of 2014, and again in 2015, which identified a number of gaps in training for staff within the Trust. Work continues with the Trust Learning and Development Lead and the Head of Security and Emergency Resilience to integrate the EPRR TNA action plan with the Trust Training Needs Action Plan.

The training that has been provided throughout the reporting year includes the following:

- 9 members of staff are trained in Decision Loggist skills and 1 staff member has been trained to deliver this course internally;
- In house training to Business Continuity Leads on how to write their Business Continuity Plans;
- Face to face training with staff on how to complete a Business Continuity Plan;
- Lockdown awareness training of higher risk clinical areas has been provided to staff so that they are aware of how to appropriately lock down their respective buildings in the event of an incident.

For the forthcoming year this training will be expanded to include the following areas:-

- Implement via NHS England EPRR Loggist training to nominated staff, so in the event an actual incident there are a number of trained staff who can accurately record events and decision making as it happens.
- Arrange for nominated staff to attend "train the trainer" Loggist training so there is a continued learning opportunity and a rolling programme as and when required.
- Review those areas if any, within BDUs to establish the requirement for manager on call training and develop a basic training package to that effect.
- Develop a basic training package for a newly appointed Director who is going to be "on call".
- Implement a rolling programme of BDU lock down training, which is delivered by way of a number of table top exercises.
- Implement a programme that complies with the monitoring of on call arrangements.
- Ensure when available Directors and senior managers have the opportunity to attend any regional strategic leadership in a crisis training that is offered.

These priorities were identified following a peer review exercise with YAS (Yorkshire Ambulance Service).

**COMPLIANCE**
The Trust has numerous external agencies that provide guidance and standards that need to be achieved. Throughout the reporting year the following achievements have been noted:

*Department of Health (ERIC Returns)*
The ERIC return, requests a response to notify of all fire events and fire alarm activations in premises owned or managed by the Trust. This request does however; exclude fire alarm activations for SWYPFT wards on other hospital sites, such as the Dales or the Priestley Unit. A total of 3 incidents were classified as "reportable fires" that required either emergency action by the fire service, or that resulted in damage to building structure during the reporting year. Two of the incidents involving smoking paraphernalia and one an accidental cooking fire.

A total of 143 fire alarm activations were noted, an 11.73% (162) reduction from the previous year. The totals include fire alarm activations where the cause of activation was investigated and fire service attendance was either not required, or cancelled prior to arrival on site. The number of fire service attendances to false alarm calls on our sites decreased from 26 to 19.

It is a point of note that under the Localism Act, Fire Authorities now have the power to charge for attendance (currently £360 plus VAT per hour); however, South and West Yorkshire Fire Safety have recognised the efforts by the Trust to reduce unwanted fire signals, and no costs were incurred for fire service attendance during the last financial year.

*NHS England - Core Standards for Emergency Preparedness, Resilience & Response*
A full organisational review against the 55 core standards confirmed that as a Mental Health and Community Provider of Healthcare; compliance against 42 of the 55 standards was required. Out of the 42 standards that were reviewed in November 2015, 25 standards were fully compliant; and an action plan has been implemented to work towards achieving compliance against the 17 areas of partial compliance.

The overall trust rating on EPRR arrangements was scored at Substantial compliance.

*NHS Protect - Security Standards for Providers*
These standards have been developed to support NHS providers in ensuring they have appropriate security management arrangements in place within their organisation, to protect staff and patients and to ensure NHS assets are kept safe and secure. Four key sections are published with a total of 30 standards detailed across all sections, these being:

- **Strategic Governance** (5 Standards)
- **Inform and Involve** (7 Standards)
- **Prevent and Deter** (14 Standards)
- **Hold to Account** (4 Standards)

The Trust declared a Green scoring of compliance with 26 out of the 30 standards being achieved, 3 being progressed and 1 to address. The Trusts response to the Self Review Tool is available at Appendix 2 that details Trust compliance across all standards. In order to address the amber and red standards, an action plan was developed, which is available at Appendix 3.

*Health & Safety Executive (HSE) and Internal Monitoring*
The Annual Health & Safety Monitoring tool was published and circulated via email in November 2015. A total of 190 self declarations against the survey, covering 317 services and teams were received.

The audit comprised of a series of questions relating to a variety of specialisms, including Health & Safety, Fire Safety, Security, Emergency Planning and Moving and Handling.

Overall the Trust has achieved 86% compliance with all the Health and Safety standards which is a slight improvement from the previous year (84%). A breakdown of BDU self-declarations is noted below:

- 54 (29%) Barnsley BDU;
- 50 (26%) Calderdale and Kirklees BDU;
- 12 (6%) Forensic BDU;
- 10 (5%) Specialist Services BDU;
- 28 (15%) Wakefield BDU;
- 36 (19%) Corporate and Support Services.

A section showing the Quality Health results for the health and safety questions from the 2015 national staff survey was also included, results of which can be found at Appendix 4.

**INCIDENTS/EVENTS**

*The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)*

RIDDOR requires the Trust to report all over seven day injuries to the Health & Safety Executive; a total of 39 such incidents were reported during 2015/2016. This was a 22% increase from 2014/2015, with violence and aggression related incidents being the major incident factor which was up by 37% on the previous year. Specialist Services recorded a rise of 5 RIDDOR's during the year – 3 from the Fox View Unit from Dewsbury that is not now operational and 3 from Horizon, where significant support was provided to the Team from Health & Safety, Security and Estates where one individual has been intensively nursed with a view to improving their health & wellbeing and an aim of integrating them into the general service user group.

Whilst there was not one individual service responsible for more than 2 RIDDOR's, all of these incidents were also reviewed by the MAVTAG and the chair seeks assurance from attendees that appropriate support has been offered to individuals. MAVTAG also look for trends or learning from RIDDOR.

A table detailing the number and type of RIDDOR incidents is available in Appendix 5, Incidents Breakdown.

*Safety Related Incidents*

A total of 6249 of safety related incidents were recorded in 2015/2016, up 5.6% (333 incidents) from 2014/2015, with violence and aggression accounting for 15.6% (additional 521 incidents). The increase in reported violence and aggression incidents mirrors the increase in RIDDOR notifications from the year. All other categories, Health & Safety, Security, Fire Slips, Trips and Falls showed encouraging improvements ranging from 2.6% to 13%.

Identified trends are brought to the attention of staff during both MAV and H&S Training as well as during audits/inspections

Health & Safety and MAV Teams continually work closely together, along with LSMS colleagues, supporting staff in the working environment to reduce the risk of Physical violence against staff. Examples of this include reviewing the physical working environment to reduce the risk of violence, reminding staff of the importance of panic alarm use and involving staff side colleagues at Health & Safety MAV TAGs.

*Moving and Handling Incidents*

The number of reported incidents has decreased from 25 reported incidents in 2014/2015 to 21 in 2015/2016. These incidents generally remain low risk and are predominantly workplace/environmental issues. 7 incidents were reported as yellow in the year and the team has responded to these incidents with appropriate assessment, training and support to individuals and mangers as indicated.

*Slips, Trips & Falls*

A total of 936 reports of Slips, Trips and Falls (a 7.8% reduction from 2014/2015), were recorded across the Trust. The majority of reported incidents affected clients within the clinical setting, followed by staff members sustaining injury whilst undertaking their daily tasks. Joint work continues with the Trust's clinical Falls Group to help ensure a coordinated approach to the issues. A table of incidents can be found at Appendix 5.

*Security Related Incidents*

Over 500 security related incidents were recorded during the financial year, with Property Incidents noted as the highest reported type, followed by Building Environment and Security. A breakdown of the Top 5 Security Related Incidents can be found at Appendix 6.

All incidents were investigated accordingly with support provided where necessary to affected staff members.

*Reporting of Physical Assaults against staff to NHS Protect*

The trust reported 809 incidents of physical assaults during 2014/15. This relates to 156 incidents/1000 staff employed. This year's figures were higher than the 706 incidents (150/1000 staff) reported in 20/1314. In 2012/13, 716 incidents were reported.

*Emergency Planning Events*

The Trust were heavily involved in the preparations and planning for the Tour de Yorkshire event that took place on 1st, 2nd & 3rd May 2015. This event passed through the geographical footprint of 3 Business Delivery Units Calderdale, Barnsley and Wakefield. Significant involvement with inter-agency contingency planning arrangements ensured the Trusts critical services were not detrimentally impacted as a result of the race passing through Yorkshire and in particular, the respective BDU's involved without incident.

A further notable event occurred on the 27th August 2015, with the Trust being subjected to a cyber-attack which subsequently resulted in some staff members being unable to access the Trust IT network, which in turn may have impacted on patient care. However, those staff members unable to access networks and systems implemented their departmental Business Continuity Plans, which ensured disruption was kept to a minimum and patient care was not affected. In addition to this, a debrief training session was undertaken at an Extended EMT meeting where the seriousness of the cyber-attack was analysed and lessons learned identified. These lessons learned included the need for IM&T to update their internal and external operating practices, such as reinforcing communications with external partners; strengthening of Business Continuity Plans would also enhance internal communication practices. An action plan has been established and IM&T leads continue works to achieve compliance against these areas.

## NOTABLE ACHIEVEMENTS 2015/2016

*Fire Safety Achievements*

- The provision of fire safety services to NHS Wakefield Clinical Commissioning Group and Spectrum Community Health via service level agreements. Services provided include specialist fire safety advice to management, fire safety training to staff and fire wardens, fire safety risk assessments and inspections.
- Fire safety risk assessments have been undertaken under contract for Barnsley Metropolitan Borough Council.

*Emergency Planning Achievements*

- Implementation of procedural documentation, including the EPRR Policy, the Adverse Weather Policy, Bomb Threat Procedures and Business Continuity Plans.
- Implementation of systems to support data management relating to Industrial Action and reporting information to NHS England.

*Health & Safety Achievements*

- Implementation of new Risk Assessment processes and Policy along with the creation of a central database to monitor activity;
- Creation and progression of a central auditing schedule following the RAG rating of premises and teams, to ensure services are audited as risk identifies.

*Security Achievements*

- Roll out of the new lone worker contract across the Trust. The contract has increased from the provision of 840 devices to that of 1200 with an additional 100 users to enable pooled systems where assessed as necessary.
- Contracted external security contract awarded to Gough & Kelly so to provide a Trustwide security service. The contract commenced on 01 November 2015.
- Cash in Transit contract awarded to Security Plus Ltd in March 2016. The service provider ensures monies from the main hospital sites are transferred securely.

**FORWARD LOOK FOR 2016/2017**

In order to ensure the continued provision of safe services across the Trust, a number of action plans and proposed objectives have been created. The Health and Safety Action Plan for 2016/2017 can be found at Appendix 7 and the Security Action Plan, already noted at Appendix 3. All other proposed objectives are noted below.

- Continue to support the Capital Planning team with the completion and occupation of the new Wakefield and Pontefract hubs, together with the re-location of staff and closure of existing buildings.
- Continue to support Trust management in monitoring and reducing the risk of fires within Trust buildings arising from non- compliance with the smoke free policy
- Implement a comprehensive programme of training for staff at all levels and grades across the Trust relating to EPRR. This programme of training will enhance staffs skills and knowledge in relation to business contingency management and operational and organisational resilience. Further to this, this training programme will also provide reassurances to NHS England's Core Standards Framework for EPRR, that suitable and sufficient arrangements are in place to achieve the respective standards attributed to this document.
- Create and implement a comprehensive procedure for handling HAZMAT/CBRN incidents in conjunction with partner organisations; although we are not an accident and emergency (A and E) receiving organisation we must still have robust arrangements in place. These arrangements can be covered by way of policy and procedures.
- Re-commission the command and control facilities at the Boardroom, Kendray; ensuring that all equipment that Is required within a command and control room is fit for purpose.
- Develop and implement a Trust wide system that ensures that BDUs undertake regular monitoring and review arrangements for their critical activity business contingency plans.
- Review all essential Trust on call arrangements within the Trust, ensuring appropriate documentation is updated and processes audited at least twice per year.
- Implement a programme of table top exercises and a "live" tests across all BDU's;
- Create and implement a Trust wide Business Continuity Plan for use in the event of a Mass Casualty Incident. This plan should have agreed organisational arrangements documented in the event of the trust losing ward(s) for significant periods of time.

**CONCLUSION**

In conclusion a significant amount of comprehensive work has been implemented within 2015/2016. Many of these works have resulted in the Trust being awarded the assurance by NHS England, NHS Protect, the CQC and overall helping to keep staff, patients and visitors safe. There still remains a programme of works to be implemented in 2016/17 to ensure that the Trust continues to be a safe place to work and be treated.

## Appendix 1

## Safety Related Training

| Course | No. |
|---|---|
| COSHH E-learning | 8 |
| COSHH Workbooks | 480 |
| Specialist Driver Safety | 7 |
| DSE E-learning | 96 |
| Emergency Aid | 62 |
| First Aid at Work Refresher | 45 |
| Health & Safety Awareness | 163 |
| Health & Safety Awareness E-learning | 35 |
| Health and Safety E Learning | 1 |
| Health and Safety Workbooks | 525 |
| Lone Working | 6 |
| M&H Basic Back Care E Learning | 147 |
| M&H Basic Back care | 1563 |
| M&H People | 518 |
| M&H Workbook | 174 |
| Risk Assessment | 138 |
| Trust Induction Welcome Days | 311 |
| **Total** | **4279** |

## Appendix 2

**SRT NHS Protect Standards**
**SRT Status Summary**
Overall Score: **GREEN**
Status: Draft

### 1. Sections

1.1. **General**

1.2. **Strategic Governance**

1.3. **Inform and Involve**

1.4. **Prevent and Deter**

1.5. **Hold to Account General**

| Standard | Comments |
|---|---|
| Name of the organisation | SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST |
| Annual budget of the organisation | £ 190 million to £ 260 million |
| Staff headcount including contracted employees | 3,000 to 6,000 |
| Organisation code | RXG |
| Organisation/provider type | Mental Health and Learning Disability |
| Co-ordinating Commissioner for this provider. | WEST YORKSHIRE COMMISSIONING HUB |
| Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management | Alan Davis |
| Region | North East |
| Date of completion of this review | |
| Name of the Local Security Management Specialist | Johan Celliers, John Sanderson and Martin Brandon |
| Substantive role if not Local Security Management Specialist | Operational security, emergency planning, logistics, Health and Safety |
| Name of the security management provider organisation (including in-house) | South West Yorkshire Partnership Foundation Trust |
| 'Inform & Involve' and 'Prevent & Deter' days used | 300 |
| 'Hold to Account' days used | 25 |
| Total days used for security management | 325 |
| Cost of security management staffing | 200 000 |
| Cost of security equipment (including physical systems) | N/A |

## Strategic Governance

| No | Standard | Rating | Comments |
|---|---|---|---|
| 1.1 | A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation. | GREEN | Yes, Alan Davis, Director of Human Resources and Workforce Development. Alan is the nominated Security Management Director (SMD). |
| 1.2 | The organisation employs or contracts a qualified, accredited and nominated security specialist(s) to oversee and undertake the delivery of the full range of security management work. | GREEN | The trust currently employs 3 accredited LSMS's. |
| 1.3 | The organisation allocates resources and investment to security management in line with its identified risks. | GREEN | Where identified by Crime reduction surveys, various capital schemes offer support and funding to the improvement of safe and secure environments and other security related schemes. Some capital schemes, local budgets, estates budgets are also |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | available to support local initiatives. |
| 1.4 | The organisation reports annually to its executive board, or equivalent body, on how it has met the standards set by NHS Protect in relation to security management, and its local priorities as identified in its work plan. | GREEN | Annual Reports and monitoring are presented to SMD and work plans are agreed. |
| 1.5 | The organisation has a security management strategy aligned to NHS Protect's strategy. The strategy has been approved by the executive board or equivalent body and is reviewed, evaluated and updated as required. | GREEN | Security strategy is captured in the Security Management Policy and is operationally implemented by various Trust Action Groups (TAGs) including Estates TAG, Health and Safety (H&S) and Emergency Prevention, Preparedness and Response (EPPR) TAG, and Management of Aggression and Violence (MAV) TAG. The strategy is also captured within the Security Management Policy. |

## Inform and Involve

| No | Standard | Rating | Comments |
|---|---|---|---|
| 2.1 | The organisation undertakes risk assessments in relation to: a) protecting NHS staff and patients b) security of premises c) protecting property and assets d) security preparedness and resilience. The organisation develops inclusive policies to mitigate identified risks relating to the above (a-d), and can demonstrate implementation of these policies. The policies are monitored, reviewed and communicated across the organisation. | GREEN | Crime Reduction Surveys completed to high risk premises (Top 50 premises), on a rolling program and RAG rated. Findings are used to guide, develop and support Security related policies and support capital bids for upgrades to security. Safe and Secure Environment Policy to guide and inform on security support and internal arrangements. |
| 2.2 | The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect | GREEN | LSMS liaise with local Police liaison officers and also attend and engage with Prevent Partnership Groups. Representation from local authorities, |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | NHS staff, premises, property and assets. | | housing, fire services, education. LSMS also attend mental health disorderly offenders Group (Multi Agency). |
| 2.3 | The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro- security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS Protect, to improve security awareness. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective. | GREEN | Security training is made available in many formats. Security alerts is disseminated as appropriate. Security awareness training and awareness week is developed and supported annually. Security awareness is monitored via security section in annual H&S monitoring tool. Security section also available on Trust Intranet. Management of Violence and Aggression and training and Conflict resolution training also included security awareness. |
| 2.4 | The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response. | GREEN | Trust has introduced specialist advisors that cover all areas of risk management, capital projects, estates, security, H&S, Fire etc. The group meets on a regular basis and agendas are set for the meetings. Estates Trust Action Group delivers on all capital and estates related actions and H&S Trust Action group deals with all policy and operational issues. Dashboard includes security assessments finding and updates to support review on capital schemes. |
| 2.5 | All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary. | GREEN | Security management component are included in the local induction for all new starters. Methods to raise awareness include: Posters, local intranet, training, awareness weeks. As in 2.3, Management of Violence and Aggression and training and Conflict resolution training also |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | includes security awareness and reporting of security related incidents. Evaluation is done via MAV TAG and |
| 2.6 | All staff who have been a victim of a violent incident have access to support services if required. | GREEN | Supporting Staff Policy and Violence Against Staff policy in place with guidance for support. Evaluation, reviewed and monitored at MAV TAG and H&S and EPPR TAG. |
| 2.7 | The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made where necessary. | RED | The trust is currently investigating the option to link the current Datix reporting systems to SIRS. A recent telephone conference was held with David Dixon and various representatives from the Trust. David Dixon has provided relevant information to the Trust's Patient Safety team, who oversees the maintenance of the Datix system, to investigate the required resources to build the SIRS platform to allow automatic upload to SIRS. This will help enhance the current Security category already |

## Prevent and Deter

| No | Standard | Rating | Comments |
|---|---|---|---|
| 3.1 | The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the appropriate level of training on prevention of violence and aggression is delivered to them in accordance with NHS Protect's guidance on conflict resolution training and the prevention and management of clinically related challenging | GREEN | The trust provides Management of Violence and Aggression (MAV) training and Conflict Resolution Training (CRT) to all front line staff. The training is made available and tailored to a variety of groups as per their own requirements. The training figures are bimonthly reviewed at the MAV TAG and actions agreed. Training is also reviewed on an annual basis and is part of the Trust mandatory training. |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | behavior. The training is monitored, reviewed and evaluated for effectiveness. | | |
| 3.2 | The organisation assesses the risks to its lone workers, including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness. | GREEN | Lone worker risk assessments are carried out by local service management under guidance from Lone Worker Policy. Staff are risk rated to determine suitability for Lone Worker Devices. LSMS and admin support monitor and raise awareness of non compliance. Use of devices are reviewed and referred back to local management if concerns are identified. |
| 3.3 | The organisation distributes national and regional NHS Protect alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored, reviewed and evaluated. | GREEN | Alerts are disseminated to agreed distribution groups and monitored for action and dissemination.<br>Appropriate alerts are discussed at TAGs. Distribution list are reviewed and updated on an annual basis. |
| 3.4 | The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds. | GREEN | Crime Reduction Surveys support and highlight access and egress concerns.<br>Concerns highlighted to local service management and where appropriate referred to Estate TAG for capital funding allocation. There is also ongoing lockdown arrangements to help identify premises that will require lockdown procedures and also upgraded physical security. |
| 3.5 | The organisation has systems in place to protect all its assets from the point of procurement to the point of decommissioning or disposal. | GREEN | Asset Control Policy has just been reviewed and is going through the ratification process. Processes are monitored through Finance, Procurement, Receipt and Distribution and Facilities |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | & Estates. Specialist advice can be sought from the Trust's LSMS where issues related to potential criminal activity and/or security breaches are identified. Policy direction and work activity within this area is monitored and evaluated by Estates Performance and Information officer to ensure internal governance arrangements |
| 3.6 | The organisation operates a corporate asset register for assets worth £5,000 or more. | GREEN | Corporate asset register is implemented and maintained by Finance Department. Annual review includes updating of register, confirmation of current assets and revaluation of assets are also monitored. |
| 3.7 | The organisation has departmental asset registers and records for business critical assets worth less than £5,000. | GREEN | Appropriate Policy direction is agreed to ensure such systems are in place. Processes are monitored through Finance, Procurement, Receipt and Distribution and Facilities & Estates and specialist advice can be sought from the Trust's LSMS where issues related to potential criminal activity and/or security breaches are identified. Policy direction and work activity within this area is monitored and evaluated to ensure internal governance arrangements are maintained. Asset register for all capital and departmental assets and asset register maintained on the Planet FM Enterprise system managed by Estate's Performance and Information Officer. |
| 3.8 | The organisation has clear policies and procedures in place for the security of medicines and controlled drugs. | GREEN | Processes and procedures for the safe management of medicines and drugs are highlighted in the Medicines Management & Pharmacy |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | Strategy and Prescription Forms - Use and Security Policy. Policy direction and work activity within this area is monitored and evaluated to ensure internal governance arrangements are maintained. Where breaches of Security and/or criminal activity are identified specialist advice or guidance is afforded by the Security Management Specialist and reported to the Local Intelligence |
| 3.9 | Staff and patients have access to safe and secure facilities for the storage of their personal property. | GREEN | Crime reduction surveys highlight concerns to local management and funding request can be resolved via Estates TAG. Staff are advised to consider safety of valuables in the work environment via training. Patient Property Policy developed from NHS Protect Guidance and is implemented. |
| 3.10 | The organisation records all security related incidents affecting staff, property and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies. | GREEN | All incidents are recorded on Datix Incident Management Systems. Reported Security related incidents are appropriately distributed to line managers, service managers, and specialist advisors to allow for appropriate post incidents support. Incident and clusters of incidents will be considered for short term action plan or annual action plans depending on risk and are highlighted at various local management groups. |
| 3.11 | The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures. | AMBER | Crime Reduction Surveys are reviewed annually and carried out on a RAG basis. Lockdown staff profile, security profile, and building profile are used to identify potential risk and put forward as evidence to improve security arrangement and capital bids. Lockdown profiles are available for some inpatient areas. |

| No | Standard | Rating | Comments |
|---|---|---|---|
| 3.12 | In the event of increased security threats, the organisation is able to increase its security resources and responses. | AMBER | In-house security and contracted security can be drafted in at short notice to increase resources in line with threat level. Lockdown staff profile, security profile, and building profile are used to identify potential risk and put forward as evidence to improve security arrangement. Lockdown profiles available for some inpatient areas. Emergency Response plan agreed for police support to Forensic services. |
| 3.13 | The organisation has suitable lockdown arrangements for each of its sites, or for specific buildings or areas. | AMBER | Lockdown staff profile, security profile, and building profile are used to identify potential risk and put forward as evidence to improve security arrangements. Lockdown profiles available for some inpatient areas. Lockdown Policy and associated training are on rolling program for implementation within in-patient areas. |
| 3.14 | Where applicable, the organisation has clear policies and procedures to prevent a potential child or infant abduction, and they are regularly tested, monitored and reviewed. | NOT APPLICABLE | |

**Hold to Account**

| No | Standard | Rating | Comments |
|---|---|---|---|
| 4.1 | The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents. | GREEN | Various trust policies are clear in relation to reporting of incidents relating to acts of violence, security related breaches, theft and criminal damage to the police. Staff are encouraged to report all incidents to line management and the police for immediate and ongoing support. LSMS support is also available |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | and highlighted within policies. Guidance given on full range of sanctions within security Management Policy. |
| 4.2 | The organisation has arrangements in place to ensure that allegations of security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated. | GREEN | The trust policies provide guidance on support for reporting of all security and violence related incidents. See Supporting Staff Policy, Management of Violence and Aggression Policy, Violence, Harassment and Bullying against Staff Policy, Lone Worker Policy, Safe and Secure Environments Policy and Security Management Policy.<br>Datix implemented to monitor, alert and investigate incidents and to prevent reoccurrence. |
| 4.3 | Where appropriate, the organisation publicises sanctions successfully applied in cases relating to: a) unnecessary access to premises; b) assaults on NHS staff; c) breaching the security of NHS premises and property; d) acts of theft and criminal damage. | GREEN | The LSMS will seek support on this area to ensure that security successes and sanction obtained against offenders are published appropriately. This is a sensitive area for a mental health organisation, but internal publication will be considered for future incidents and other forums for discussion of success to be considered. See publication section in Security Management |
| 4.4 | The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness. | GREEN | The Trust has clear Policy guidelines in relation to the recovery of financial losses and such Policy direction is monitored and evaluated to ensure effectiveness and internal governance arrangements are maintained. Financial losses are monitored through internal Audit Committee and this can evidenced. The LSMS will seek to address cases where such losses are |

| No | Standard | Rating | Comments |
|---|---|---|---|
| | | | identified due to Criminal Activity and/or security breaches. The LSMS will work to implement a contact/referral procedure with finance to allow for further investigation and/or specialist guidance and advice. |

Appendix 3

| **Security Management Action Plan 16/17** | | | | | |
|---|---|---|---|---|---|
| **Date: 16/02/2016 Security Management – Recommendations and Action Plan** | | | | **Ref No:**<br><br>**Initials:** | SRT15/16<br><br>JC |
| SRT Standard and Recommendations | Action (To include how evidenced) | Lead Responsibility | Date Completion Due | Individual/ Group Responsible for Monitoring Action Plan | Date Actually Completed |
| 1. Standard 2.7 Explore SIRS. This process is to be reviewed, evaluated and implementation explored to ensure compliance | The trust is currently investigating the option to link the current Datix reporting systems to SIRS. A recent telephone conference was held with David Dixon (SIRS Lead) and various representatives from the Trust. David Dixon has provided relevant information to the Trust's Patient Safety team, who oversees the maintenance of the Datix system, to investigate the required resources to build the SIRS platform to allow upload to SIRS. Patient Safety team had advised that they will only be able to explore after 1 April 2016. | LSMS and patient safety team. | 31/3/17 | LSMS, SMD and Patient Safety Team. | |
| 2. Standard 3.11: Risk based approach to identifying and protecting assets, as per Safe and Secure Environ – no reference to this in our policies, however we have started the roll out of | Risk based approach included Safe and Secure Environments Policy and refer to crime reduction surveys. Ongoing review of Crime Reduction Surveys of premises to ensure risk based approach to identifying, implementing and evaluating security measures at Trust premises on the back of this process. Feedback regarding CRS work is reported at | LSMS and specialist advisors | 31/3/17 | LSMS, SMD and H&S PAG and Estates PAG | |

| Security Management Action Plan 16/17 | | | | | |
|---|---|---|---|---|---|
| **Date: 16/02/2016 Security Management – Recommendations and Action Plan** | | | | **Ref No:**<br><br>**Initials:** | SRT15/16<br><br>JC |
| SRT Standard and Recommendations | Action (To include how evidenced) | Lead Responsibility | Date Completion Due | Individual/ Group Responsible for Monitoring Action Plan | Date Actually Completed |
| | Estates PAG within the Estates and Facilities Performance Dashboard. | | | | |
| 3. Standard 3.12 In the event of increased security threats, the organisation is able to increase its security resources and responses. | In-house security and contracted security can be drafted in at short notice to increase resources in line with threat level. Newly appointed contracted security provider can provide 10 extra men, at short notice, to any one of our premises within hour. Extra security can be provided but will be outside of 1 hour timeframe.<br>Emergency Response plan agreed for police support to Forensic services. | LSMS | 31/3/17 | LSMS, SMD, H&S PAG and EPRR PAG | |
| 4. Standard 3.13 continue to work to create and implement suitable Lockdown arrangements for each of its priority sites, or for other specific buildings/areas of priority. Lockdown policy reviewed and approved. Continue to ensure effectiveness of the organisation's lockdown arrangements. | Continue to Identify priority areas for Lockdown.<br>Review lockdown profiles (security-, building- and staff profiles)<br>Identify training requirements.<br>Complete more table top and live exercises within local services to test effectiveness.<br>Review and audit lockdown arrangements. | LSMS | 31/3/17 | LSMS, SMD, H&S PAG | |

| **Security Management Action Plan 16/17** | | | | | |
|---|---|---|---|---|---|
| **Date: 16/02/2016 Security Management – Recommendations and Action Plan** | | | | **Ref No:**<br><br>**Initials:** | SRT15/16<br><br>JC |
| SRT Standard and Recommendations | Action (To include how evidenced) | Lead Responsibility | Date Completion Due | Individual/ Group Responsible for Monitoring Action Plan | Date Actually Completed |
| | | **This section for completion by Lead Director(s) only:** | I can confirm that the above recommendations have been actioned and implemented.<br>Signed:<br>……<br>Date:…….. | | |

## Appendix 4

### National Staff Survey Results

This section provides the results from some questions in the National NHS Staff Survey which directly map to the Health and Safety Executive (HSE) Management Standards. The results below are provided by Quality Health (QH). There were 409 respondents from the Trust in 2015.

| NHS Staff Survey Health and Safety optional questions 2014 | Strongly agree or Agree | Neither Agree or Disagree | Strongly disagree or Disagree | Data missing |
|---|---|---|---|---|
| Senior managers in this organisation promote a culture of patient/service user safety. | 72% (287) | 25% (98) | 3% (11) | 13 |
| There is a clear and effective system of reporting health and safety issues across this organisation. | 84% (336) | 14% (56) | 2% (7) | 10 |
| Sufficient measures are in place to identify health and safety risks in this organisation. | 77% (306) | 19% (77) | 4% (15) | 11 |
| Staff are encouraged to carry out routine risk assessments. | 66% (264) | 25% (101) | 9% (34) | 10 |
| Staff are encouraged to challenge safety practices if they are not working. | 71% (281) | 23% (92) | 6% (25) | 11 |
| Patient/service user safety is never sacrificed to get more work done. | 55% (217) | 31% (122) | 14% (56) | 14 |
| Staff uphold good safety standards in this organisation. | 78% (311) | 20% (79) | 2% (7) | 12 |
| In my team/department, we discuss ways to improve staff/patient safety. | 67% (264) | 23% (93) | 10% (40) | 12 |
| Patient/service user feedback is taken into consideration when evaluating ways to improve safety. | 55% (208) | 36% (137) | 9% (32) | 12 |
| We have patient/service user safety problems in this organisation. | 27% (105) | 41% (163) | 32% (128) | 13 |

## Appendix 5

## Incidents Breakdown

### 1. RIDDOR Incidents 2015/2016

| | Health and Safety (including fire) | Slips, Trips and Falls | Violence and Aggression | Total |
|---|---|---|---|---|
| Barnsley Mental Health and Substance Misuse (BDU) | 3 | 0 | 5 | 8 |
| Barnsley General Community Services | 0 | 1 | 0 | 1 |
| Calderdale | 1 | 1 | 0 | 2 |
| Kirklees | 0 | 1 | 2 | 3 |
| Wakefield | 1 | 1 | 3 | 5 |
| Forensic Service | 2 | 3 | 7 | 12 |
| Specialist Services | 1 | 0 | 5 | 6 |
| Trust wide (Corporate support services) | 2 | 0 | 0 | 2 |
| Total | 10 | 7 | 22 | 39 |

### 2. Slips Trips & Falls Summary

| | Barnsley Mental Health and Substance Misuse (BDU) | Barnsley General Community Services | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Trust wide (Corporate support services) | Total |
|---|---|---|---|---|---|---|---|---|---|
| Slip, trip or fall - other/visitor | 0 | 3 | 0 | 0 | 1 | 1 | 0 | 3 | 8 |
| Slip, trip or fall - patient | 59 | 128 | 89 | 241 | 285 | 39 | 31 | 0 | 872 |
| Slip, trip or fall - staff member | 3 | 8 | 4 | 11 | 10 | 7 | 8 | 5 | 56 |
| Total | 62 | 139 | 93 | 252 | 296 | 47 | 39 | 8 | 936 |

## 3. Comparative Year on Year Safety Related Categories

| Reported Categories | Barnsley Mental Health and Substance Misuse (BDU) | | Barnsley General Community Services | | Calderdale | | Kirklees | | Wakefield | | Forensic Service | | Specialist Services | | Trust wide (Corporate support services) | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Years | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 | 14/15 | 15/16 |
| Security breaches | 43 | 60 | 67 | 67 | 38 | 29 | 55 | 45 | 68 | 49 | 253 | 185 | 25 | 41 | 24 | 22 | 573 | 498 |
| Health and Safety (including fire) | 97 | 76 | 93 | 93 | 98 | 85 | 174 | 148 | 147 | 137 | 330 | 279 | 74 | 111 | 44 | 39 | 1057 | 968 |
| Slips, Trips and Falls | 35 | 62 | 161 | 139 | 113 | 93 | 243 | 252 | 287 | 296 | 69 | 47 | 41 | 39 | 11 | 8 | 960 | 936 |
| Violence and Aggression | 201 | 312 | 33 | 38 | 616 | 491 | 516 | 724 | 738 | 880 | 906 | 989 | 309 | 401 | 7 | 12 | 3326 | 3847 |
| Total | **376** | **510** | **354** | **337** | **865** | **698** | **988** | **1169** | **1240** | **1362** | **1558** | **1500** | **449** | **592** | **86** | **81** | **5916** | **6249** |

## Appendix 6

### Top 5 Security Related Incidents

The top 5 reported security categories were:

- **Property Incidents (including accidental loss/missing property) – 164 incidents** (This is up 13 incidents from 151 in 2014/15). These incidents identify issues that do not have an immediate financial implication to the Trust, however do not issues such as buildings, doors and windows left unsecure and failure of security systems. Yellow and Amber figures noted below:

| | No harm or injury occurred (Green no harm) | Minor injury, impact or intervention (Green) | Moderate injury, impact or intervention (Yellow) | Major (serious) injury, impact or intervention (Amber) | Total |
|---|---|---|---|---|---|
| Property (including accidental loss/missing property) | 143 | 18 | 2 | 1 | 164 |

  - **Yellow incidents include the loss of a Trust Laptop and pager; the amber alert noted the loss of a prescription pad**

- **Building and Environment Security – 151 incidents** (Down from 206 incidents in 2014/15)**.** These incidents identify the loss of property belonging to clients, staff and the Trust. The figures demonstrate that over half of these incidents note the loss of Trust equipment/property. Yellow and Amber figures noted below:

| | No harm or injury occurred (Green no harm) | Minor injury, impact or intervention (Green) | Moderate injury, impact or intervention (Yellow) | Major (serious) injury, impact or intervention (Amber) | Total |
|---|---|---|---|---|---|
| Building and environment security | 110 | 17 | 24 | 0 | 151 |

  - **Yellow incidents Include incidents like lost ID cards, fobs etc.**

- **Security – Other - 73 incidents**

| | No harm or injury occurred (Green no harm) | Minor injury, impact or intervention (Green) | Moderate injury, impact or intervention (Yellow) | Major (serious) injury, impact or intervention (Amber) | Total |
|---|---|---|---|---|---|
| Security - Other | 54 | 9 | 8 | 2 | 73 |

  - **2 amber incidents**: Both related to clinical incident. First incident was an attempted AWOL and the second in other incident related to an out-patient who did not want to the leave the out-patient department and the hospital grounds after an assessment

- **Damage including Vandalism – 69 incidents**

| | No harm or injury occurred (Green no harm) | Minor injury, impact or intervention (Green) | Moderate injury, impact or intervention (Yellow) | Major (serious) injury, impact or intervention (Amber) | Total |
|---|---|---|---|---|---|
| Damage (deliberate - e.g. Vandalism) | 40 | 20 | 9 | 0 | 69 |

- Majority of **yellow incidents** relate to damage to ward environments i.e. walls, doors seclusion rooms.

- **Theft of property- 18 incidents**

| | No harm or injury occurred (Green no harm) | Minor injury, impact or intervention (Green) | Moderate injury, impact or intervention (Yellow) | Major (serious) injury, impact or intervention (Amber) | Total |
|---|---|---|---|---|---|
| Theft - Including Alleged | 14 | 3 | 1 | 0 | 18 |

- **Yellow incident** relates to theft of lead from the Keresforth Centre

**A total of 45 Yellow incidents were recorded.**

**Appendix 7**

# Health & Safety Action Plan – 2016/2017

| Task/objective | Lead Director/ Senior Manager | Lead Officer(s) | Rationale | Target For Completion | Comments |
|---|---|---|---|---|---|
| 1. Ensure the Health & Safety team continue to support and underpin the Trust Patient Safety Strategy 2015-18 | Alan Davis/Nick Phillips | Roland Webb | " The Trust is committed to providing high quality, safe, effective and accessible care", especially pertinent with CQC patient H&S powers | Q1 | The Health & Safety Team will continue to work in partnership, both with internal colleagues and third parties to help underpin the Trust Patient Safety Strategy 2015-18 |
| 2. Working at Height Policy & Guidance to review | Alan Davis/Nick Phillips | Roland Webb | Existing policy has matured and requires full review | Q2 | Working at Height issues continue to be of concern and remain a high priority for the HSE & Trust |
| 3. Review & update Control of Contractors Policy & Guidance | Alan Davis/Nick Phillips | Roland Webb | Existing policy has now matured and requires updating | Q3 | Revised policy and guidance to reflect control and management of premises hosting Agile Working |
| 4. Environmental Training Work Book to support new Trust policy | Alan Davis/Nick Phillips | Roland Webb | Environmental policy supports the Trust new business initiatives | Q3 | Environmental training offer is fundamental constituent of all environmental systems. |

| | | | | | |
|---|---|---|---|---|---|
| 7. Implement and complete audit/inspection programme by end of March and prepare for 2016/2017 monitoring programme | Alan Davis/Nick Phillips | Roland Webb/ Richard Galliford/Steve Amos/ | Ensure effective Trust wide approach to health & safety monitoring and inspections for Trust Board assurance. | Q3<br>Q4 | The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust. |
| 8. Develop further, effective and robust links with a range of key Trust Business partners, including local CiC's CCG's and Local Authorities | Alan Davis/Nick Phillips | Roland Webb | To develop a consistent Trust wide approach with Trust business partners in line with existing models | Q4 | Health & Safety will be supporting and working with partner organisations, "so we can be relevant today and ready for tomorrow" |
| 9. Ensure policies and all Health & Safety Information updated with all correct phone numbers | Alan Davis/Nick Phillips | Roland Webb/ Richard Galliford/Steve Amos/ | To ensure Trust staff have reliable and pertinent access to Health & Safety Information | Q4 | As the roll out of new telephone numbers evolves and premises evolve, Health & Safety information will be updated as required. |
| | | | | | Health & Safety Training |

# Trust Board 28 June 2016
# Agenda item 7.1

| | |
|---|---|
| **Title:** | **Annual report, accounts and Quality Report 2015/16** |
| **Paper prepared by:** | Directors of Finance, Corporate Development and Nursing, Clinical Governance and Safety |
| **Purpose:** | To enable Trust Board to receive and adopt the annual report, accounts and Quality Report for 2015/16. |
| **Mission/values:** | The annual report, accounts and Quality Report form part of the Trust's governance arrangements, which support the Trust's mission and values. The annual report provides a summary of the Trust's performance, the accounts demonstrate financial probity and the Quality Report outlines the Trust's approach to quality, improvement in services and achievement of its quality priorities. |
| **Any background papers/ previously considered by:** | The full annual report, accounts and Quality Report for 2015/16 are available on request for members of Trust Board. This suite of documents will be available to the public once they have been laid before Parliament at the end of June 2016. |
| **Executive summary:** | <u>Background</u><br>The Audit Committee has delegated authority from Trust Board to review, scrutinise and approve the annual report, accounts and Quality Report. The Committee reviewed and approved the documents for 2015/16 at its meeting on 23 May 2016. The report and accounts with supporting documents were submitted to Monitor in line with the national timetable and have been submitted to the Department of Health for Laying before Parliament.<br><u>Annual report 2015/16</u><br>The annual report was developed in line with Monitor's requirements and this was confirmed by the Trust's external auditors. The Committee approved the report.<br><u>Annual accounts 2015/16</u><br>The Audit Committee considered the report from the Director of Finance on the final accounts (attached for Trust Board), the Head of Internal Audit Opinion (see below) and the findings of the external auditors, Deloitte (ISA 260 attached for Trust Board). The Trust met all its financial targets and achieved a Monitor continuity of services risk rating of 4. The Trust received an unqualified audit opinion on the 2015/16 accounts and a positive opinion on the requirement to demonstrate Value for Money.<br>The Head of Internal Audit Opinion for 2015/16 provided significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.<br>The Committee approved the accounts for 2015/16.<br><u>Quality Report</u><br>As requested by Trust Board, the Quality Report was scrutinised in detail by the Clinical Governance and Clinical Safety Committee prior to its |

| | |
|---|---|
| | presentation to the Audit Committee and a recommendation made for it to be formally approved. The Quality Report will be published on the NHS Choices website at the end of June 2016.<br><br>The external assurance review conducted by Deloitte was received by the Audit Committee on 23 May 2016 (included in these papers for Trust Board with the Trust's response to audit recommendations). Deloitte was satisfied with the content and consistency of the report.<br><br>Deloitte also undertook a data quality review of two nationally mandated indicators (access to crisis home-based treatment and delayed transfers of care). No issues were found in relation to crisis home-based treatment and no recommendations made. A 'B' rating was given for delayed transfers of care (DToC) to reflect some minor discrepancies and one recommendation was made. A limited assurance opinion was issued by Deloitte.<br><br>Deloitte also undertook a review of the local indicator chosen by the Members' Council in relation to care planning. Deloitte made a number of observations in relation to the indicator and the data and four recommendations were made, which the Trust will address by the end of June 2016.<br>The Committee approved the Quality Report for 2015/16.<br><br><u>Members' Council</u><br><br>The annual report, accounts and Quality Report and associated auditors' reports will be presented to the Members Council on 22 July 2016.<br><br>As required, the Trust's annual report, accounts and Quality Report were sent to the Department of Health for Laying before Parliament. When this has been done, the documents will be submitted to Monitor and included on the Trust's website. |
| **Recommendation:** | **Trust Board is ASKED to RECEIVE and ADOPT the annual report, accounts and Quality Report for 2015/16.** |
| **Private session:** | Not applicable |

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

# Prepared for the Audit Committee 23 May 2016
# Director of Finance report on Annual Accounts for the financial year 2015/16

## 1. Introduction

The Trust is required to submit its financial position for the period 1 April 2015 to 31 March 2016 to Monitor before 27 May 2016. This report provides an analysis of the balances within the accounts and links them back to the overall Trust position reported in-year to Trust Board.

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

The content of the annual report has been reviewed by the Trust's external auditor to ensure it meets disclosure requirements. Trust Board agreed the processes and content of the Annual Report and the Quality Report/Accounts.

## 2. Trust Financial Performance 2015/16

The Trust's planned annual surplus for 2015/16 was £100,000 with an actual surplus of £207,000 which overall was £107,000 better than the revised plan. Capital expenditure for the year was £11.2 million against an original plan of £12 million reflecting negotiation of better prices in the information management and technology capital programme.

As at the end of March 2016, Monitor's financial risk rating (Continuity of Service Risk Rating (COSRR)) rated 4 as planned (with 4 being the highest possible rating).

The Trust's cash position remained strong throughout the year with sufficient resources to meet its outgoings ending the year with a cash balance of £27 million against a plan of £24 million. Surplus balances were reviewed in line with the Treasury Management Policy.

Although not a requirement for Monitor, Trust Board supports the NHS Better Payment Practice Code, which sets a target of paying 95% of valid invoices within 30 days of receipt. The Trust paid 96% of non-NHS invoices within 30 days. In addition, the Government has requested all public sector bodies to pay local small and medium sized suppliers within ten workings days. In response to this, the Trust paid 77% of local suppliers within ten days during 2015/16 to help sustain local communities. Work remains ongoing to maintain and improve these payment rates.

The Trust delivered cost improvements in 2015/16 totalling £8.3 million against a plan of £9.7 million. This performance included £5.7 million in line with the original plan with £2.6 million found through mitigations and substitutions. Of the £2.6 million, £0.2 million was identified recurrently and £2.4 million non-recurrently.

## 3. Background

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

The accounts are included in full in the annual report as required by Monitor, which are subject to review by Deloitte as the Trust's external auditor, who are required to give a formal opinion on the accounts.

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

## 3.1 Annual Accounts

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

## 3.2 Summarisation Schedules (FTCs)

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

## 3.3 Submission Deadlines and Adjustments

For 2015/16, the draft accounts were required to be submitted to Monitor and made available to the auditor by noon on 22 April 2016. The accounts were submitted on time. The audited accounts should be received by Monitor no later than 27 May 2016 (uploaded and posted).

The audit commenced on 25 April 2016.

## 3.4 Annual Governance Statement

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

The Trust is required to disclose any significant matters in the Annual Governance Statement. For this accounting period the key strategic risks outlined in the organisational risk register include:

- the financial and operational risk of managing the transition in the five year plan;
- implementation of transformation programme will increase clinical risk ;
- impact reduction in local authority budgets;
- local commissioning intentions impacting on clinical, operational and financial viability;
- impact of moving from block contracts to new currency models;
- capture of clinical information on clinical systems and the impact of the upgrade of the Trust clinical information system;
- higher bed occupancy as a result of acuity causing pressure on bed-based services;
- security of funding for CAMHS services; and
- adverse reputational impact due to reported information governance incidents.

## 3.5 Accounting Policies

For 2015/16, the Trust updated its accounting policies in line with changes in accounting standards and associated guidance. Changes to these policies were discussed and approved by Audit Committee in January 2016 before adoption. There was no requirement for any prior period adjustments.

### 3.6 Major Judgement Areas

Trust Board has approved a challenging cost saving programme for 2016/17 and beyond. As a result, a number of posts are at risk and will result in a number of redundancies. This affects approximately 74 whole time equivalent (wte) posts during 2016/17 and 51 wte further redundancies during 2017/18. The Trust has estimated the associated redundancy costs and made provision for them in the 2015/16 accounts.

## 4.0 Analysis of the Annual Accounts

### 4.1 Statement of Comprehensive Income (Income & Expenditure Account)

#### 4.1.1 Income

Total income for the year was £229.8million (£237.74 million for 2014/15). This is split into income from healthcare activities and other operating income. In 2015/16 income from healthcare activities reduced by £8 million primarily due to tariff deflation applied through contract negotiations (as experienced nationally). Other operating income was £16.6 million in 2015/16 compared to £16.5 million 2014/15.

#### 4.1.2 Expenditure

Total operating expenditure reduced by £5 million to £226.8 million (£231.9 million in 2014/15). Expenditure is detailed in note 6 of the accounts. Staffing costs and number of staff employed are in note 7 of the accounts

#### 4.1.3 Operating Surplus

The Trust's 2015/16 operating surplus before dividends and interest is £3.1 million compared to the surplus in 2014/15 of £5.8 million.

#### 4.1.4 Interest

Interest received on bank deposits during the year was £89,000 (£95,000 2014/15). No interest payments were made during the year.

This is in line with the Trust's Treasury Management Policy and the amendments to the Public Dividend Capital (PDC) calculation. Whilst higher rates of interest (although not as high as previously experienced) could have been achieved with external investment maintaining funds with the Government Banking Service has realised the greatest overall financial benefit to the Trust.

#### 4.1.5 Public Dividend Capital (PDC)

Public dividend capital dividend payable during the year amounted to £3 million (£2.8 million 2014/15).

#### 4.1.6 Retained Surplus

The Trust's retained surplus after interest, taxation, depreciation and amortisation for 2015/16 was £207,000 (£3.1 million in 2014/15). No financial support was provided to the Trust during the year and the Trust received no loans.

### 4.2 Statement of Financial Position (Balance Sheet)

#### 4.2.1 Non-Current Assets (Fixed Assets)

Non-Current Assets have increased by £7.5 million from 2014/15 (7%). This brings the total non-current assets to £114.1 million. The movement represents the net of the Trust Capital programme, in year depreciation and revaluation of existing estate.

**Intangible Assets**

Intangible assets have reduced by £27,000 in year and the assets have been depreciated.

### Property, Plant and Equipment – PPE

Note 14 of the accounts provides details of the changes in PPE. In summary, the changes reflect an increase for the capital expenditure less any depreciation during the reporting period, and include the impact of any asset revaluation. A total of £11 million was included as additions to capital assets during 2015/16. The main schemes included:

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

Total depreciation for the year was £6.4 million.

### Investment Property

The value of Trust Investment Property in year is £0.15 million, a reduction of £0.19 million following the in-year disposal of a Trust asset.

### 4.2.2 Stock

Over the twelve-month period there has been a £14,000 reduction in stock. There has been no change in counting or accounting policy around stock.

### 4.2.3 Trade and Other Receivables (Debtors)

Receivables have increased by £1.9million from 31 March 2015. Further detail is provided in note 20 of the accounts. The main factor for this increase was the sale of the Aberford Field site, which was recognised in 2015/16 although the cash was not received by the Trust until 1 April 2016.

### 4.2.4 Cash

Cash at bank and in hand was £27.1 million as at 31 March 2016 (£32.7 million at 31 March 2015).

### 4.2.5 Trade and Other Payables (Creditors)

Trade and other payables have reduced by £1.3 million overall on last year. Further detail is provided in note 22 of the accounts.

### 4.2.6 Provisions (Current and Non-Current)

There has been an overall increase of £1.9 million in provisions over the period. This mostly relates to the provision for future redundancy costs recognising both the ongoing transformation agenda and the 2016/17 Cost Improvement Programme. The total provision at 31 March 2016 is £10 million (£8.1 million 31 March 2015) and is detailed in note 24 of the accounts.

### 4.2.7 Statement of Changes in Taxpayers Equity (Capital and Reserves)

Details of all reserve movements for the accounting period are on page 4 of the accounts. The significant movements in-year relate to the retained surplus for the accounting period and the impact of the revaluation exercise.

## 4.3 Statement of Cash Flow

The Trust has £27.1 million of cash as at 31 March 2016 (£32.6 million at 31 March 2015) which represents a reduction of £5.5 million. The main reason for this reduction is the capital programme undertake in the year.

The interest received in the period was £89,000.

Cash outflows included capital expenditure £11.1 million and £3 million for dividend payments. It also included the movement in debtors and the increase in accruals values.

## 4.4 Remuneration Report

The Trust is required by its Regulators to make available to the public details of senior managers' remuneration. Full remuneration and pension reports have been included in the annual report and in the accounts at note 37.

Directors' Performance Related Pay is yet to be finalised for 2015/16 as it is linked to the outcome of the Care Quality Commission inspection in March 2016.

Overall the remuneration ratio has increased from 6.4 to 6.7.

**Jon Cooke**
**Interim Director of Finance**
**23 May 2016**

Deloitte.

# South West Yorkshire Partnership NHS Foundation Trust

## Final report to the Audit Committee on the 2015/16 audit

26 May 2016

the Distinctive audit

# Contents

## Our final report



## Appendices

# Partner Introduction

# Partner introduction

## The key messages in this report

Audit quality is our number one priority. When planning our audit we set the following audit quality objectives for this audit:

A robust challenge of the key judgements taken in the preparation of the financial statements.

A strong understanding of your internal control environment.

A well planned and delivered audit that raises findings early with those charged with governance.

the Distinctive audit

I have pleasure in presenting our final report to the Audit Committee for the 2015/16 audit. I would like to draw your attention to the key messages of this paper:

| | |
|---|---|
| **Conclusions from our testing** | • The key judgements in the audit process related to: Valuation of the Trust's Property Assets; Revenue recognition in relation to CQUIN Income; valuation of Laura Mitchell House and New Street specifically. The Agresso Software Upgrade had been identified as a risk, however this was not implemented during the year and is therefore not referred to in this section.<br>• Whilst there remains a number of elements of our work still to complete, based on the current status of our audit work, we envisage issuing an unmodified audit opinion.<br>• We have not identified any inconsistencies between the Financial Statements and the FTCs. |
| **Quality Accounts** | • The findings from our work are set out in the accompanying paper, which will also be presented to the Council of Governors at their next meeting. |
| **Insight** | Based on testing to date, we have identified insights in the following areas:<br>• Fixed assets,<br>• CQUIN Income,<br>• Leases,<br>• IT findings, and<br>• Issuing of instructions to the valuer. |
| **Status of the audit** | • Our work is now complete. |

# Responsibilities of the Audit Committee

## Helping you fulfil your responsibilities as an Audit Committee

The primary purpose of the Auditor's interaction with the Audit Committee

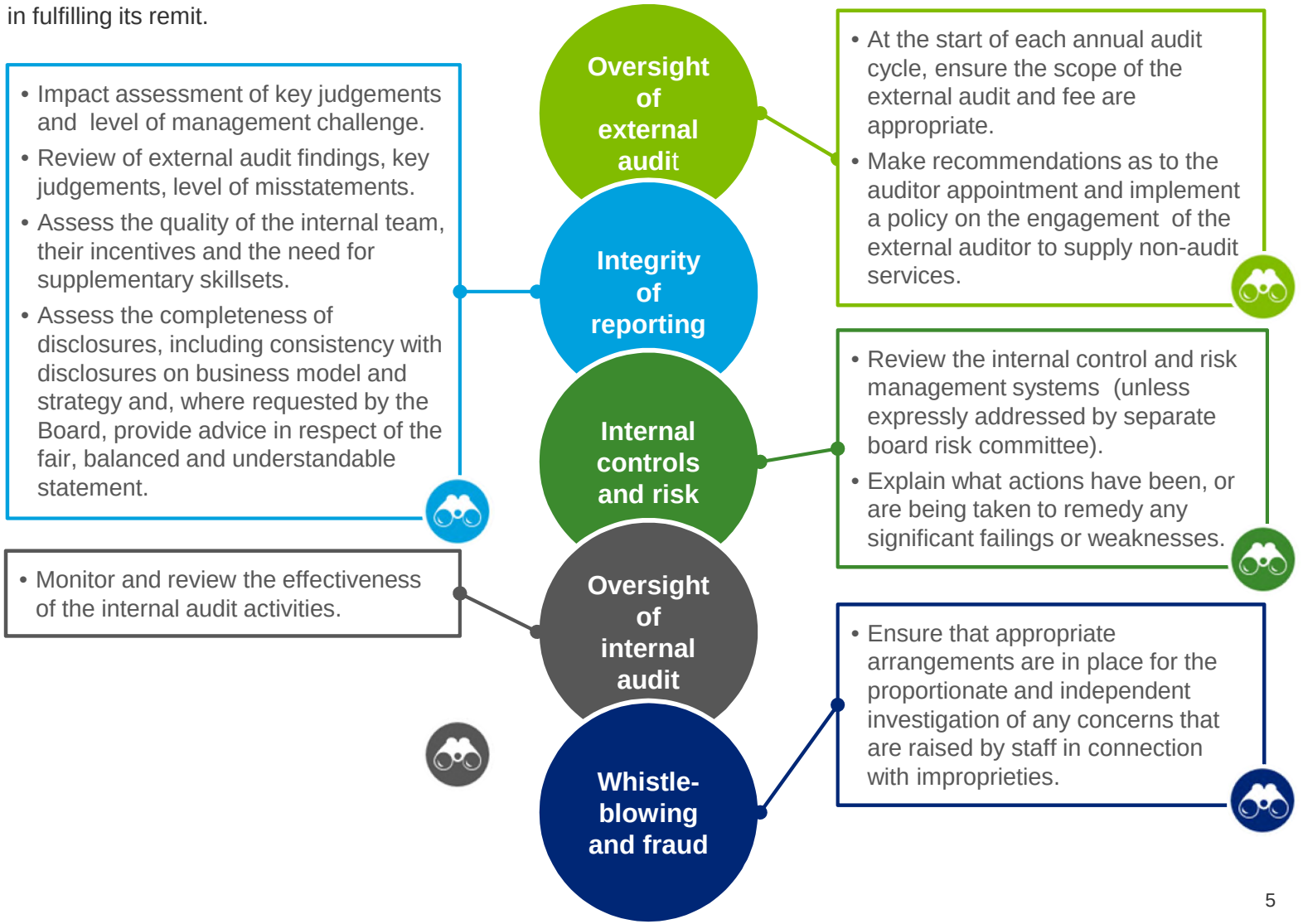
**Clearly communicate the planned scope of the financial statements audit**

**Provide timely observations arising from the audit that are significant and relevant to the Audit Committee's responsibility to oversee the financial reporting process**

**In addition, we seek to provide the Audit Committee with additional information to help them fulfil their broader responsibilities**

We use this symbol throughout this document to highlight areas of our audit where the Audit Committee need to focus their attentions.

As a result of regulatory change in recent years, the role of the Audit Committee has significantly expanded. We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of these broader responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.



# Our audit explained

## We tailor our audit to your business and your strategy

**Identify changes in your business and environment**

In our planning report we identified the key changes in your business and articulated how these impacted our audit approach.

**Scoping**

We have completed our audit in line with our audit plan, NAO Value for Money requirements and Monitor Quality Account requirements.

**Other findings**

As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. We would like to draw to your attention the insights raised and further detail of which is found on page 14.


**Determine materiality**

- We have determined our materiality as £2.27m (2014/15: £2.34m), We have used 1% (2014/15: 1%) of forecast income as the benchmark for determining materiality. On the basis of this materiality level we report to you all misstatements found in excess of £113.5k (2014/15 £117k).

**Significant risk assessment**

Our planning report explained our risk assessment process and detailed the significant risks we have identified on this engagement. We report our findings and conclusions on these risks in this report.

**Conclude on significant risk areas**

We draw to the Audit Committee's attention our conclusions on the significant audit risks. Outcomes noted on pages 8-12.

**Our audit report**

Based on the current status of our audit work, we envisage issuing an unmodified audit report.

# Significant Risks

# Significant audit risks

## Revenue recognition in respect of CQUIN Income

| | |
|---|---|
| **Risk identified** | International Standards on Auditing (UK & Ireland) 240: The auditor's responsibility to consider fraud in an audit of financial statements requires us to presume that there is a risk of fraud and error in revenue recognition. At the Trust the risk of revenue recognition is deemed to be applicable to the recognition of income from the Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. It therefore is subject to variations. |
| **Key judgements and our challenge of them** | The key judgement in the recognition of the revenue is assessing whether the relevant performance criteria have been met. As part of our work we have completed a retrospective review of the accuracy of management estimation techniques used in the application and allocation of CQUIN income and challenge this. |
| **Deloitte response** | • We assessed the design and implementation of management controls aimed at challenging, validating and agreeing the original CQUIN target measures and for reviewing progress against the target;<br>• We obtained evidence that CQUIN income for Q1-Q3 was agreed between the Trust and the Commissioners, ensuring that the income recognised by the Trust was in line with that which had been agreed;<br>• We reviewed the Q4 estimate of CQUIN income and agreed this to communication with the Commissioners; and<br>We have completed our testing of CQUIN income and note a favourable difference of £309k between income recorded at the year end and the amounts agreed as part of the exception reporting. Please see page 35 for further detail. |
| **Inclusion in our audit report** | We have referred to this risk in our auditor's report as it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team. |

# Significant audit risks

## Property Revaluations

| | |
|---|---|
| **Risk identified** | The Trust is required to hold property assets within Property, Plant and Equipment on a modern equivalent asset valuation (MEAV) basis. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. Where existing properties are being modernised, the “modern equivalent use” valuation rules can lead to a “day one” impairment where the accumulated cost of the asset exceeds the cost of a newly built facility. |
| **Key judgements and our challenge of them** | The key judgments are contained within the mechanics of the valuation assessment in which regard management have instructed an external specialist (the District Valuer (DV)) to provide an expert opinion.<br><br>We used our valuation specialists, Deloitte Real Estate to review and challenge the appropriateness of the assumptions used by the District Valuer under instruction from management in the year-end valuation of the Trust’s properties. |
| **Deloitte response** | • We have reviewed the Trust’s capital and valuation plans as part of the planning process with input from our property specialists, Deloitte Real Estate to review the valuation.<br>• The Trust carried out a desktop valuation for the purposes of the 31 March 2016 financial statements, which was reviewed by DRE and the core audit team.<br>• We assessed the reasonableness of the key assumptions used in the valuation.<br>• We examined the accuracy of the posting of the final valuation to the general ledger and financial statements.<br>• We have examined the independence of the District Valuer and are satisfied with this.<br><br>We are satisfied that the work completed of the DV is of a reasonable standard and that key assumptions are appropriate. |
| **Inclusion in our audit report** | We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team. |

# Significant audit risks

## Laura Mitchell House and New Street brought into use

| | |
|---|---|
| **Risk identified** | The Trust has had an extensive £12m capital programme, including £5m of spend on the Community Hub at Laura Mitchell House and the New Street refurbishment. There is a risk around the valuation of these assets when they were brought into use, determining whether costs should be capitalised under International Financial Reporting Standards, and also when to commence depreciation. In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down. Where existing properties are being modernised, the “modern equivalent asset” valuation rules can lead to a “day one” impairment where the accumulated cost of the asset exceeds the cost of a newly built facility. |
| **Key judgements and our challenge of them** | The key judgements include the decision as to whether expenditure should be classified as capital during the construction phase, whether there are indicators of impairment to the asset at the balance sheet date where the project remains incomplete and, finally, the valuation of the asset upon completion and transfer to operational use.<br>• We reviewed the transfer of assets from assets under construction to operational assets during the year and reviewed the valuation and depreciation treatment of these transfers.<br>• We reviewed management’s assessment of impairments to the value of cost held in assets under construction.<br>• We reviewed management’s processes to evaluate the value in use of the assets upon bringing into service as part of the assessment of the work of the District Valuer as set out on page 9. |
| **Deloitte response** | In addition to the work outlined above in respect of the specific judgment areas we also examined the transfer of items from assets under construction to operational assets during the year and reviewed the valuation and depreciation treatment of these transfers.<br>We are satisfied that the work completed by the District Valuer is of a reasonable standard and that key assumptions are appropriate.<br>Through our work on the additions into assets under construction (AUC) we noted that the first draft of the financial statements incorrectly allocated circa £5m of additions in respect of Laura Mitchell and New Street directly into buildings rather than accumulating into AUC and then transferring to Buildings upon completion. This was agreed with management and an adjustment has been posted to the financial statements. |
| **Inclusion in our audit report** | We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team. |

# Significant audit risks

## Management Override of Controls

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|---|---|
| **Risk identified** | International Standards on Auditing requires auditors to identify a presumed risk of management override of control. This presumed risk cannot be rebutted by the auditor. This recognises that management may be able to override controls that are in place to present inaccurate or even fraudulent financial reports. |
| **Key judgements and our challenge of them** | We have considered the overall sensitivity of judgements made in the preparation of the financial statements, and our work has focused on:<br>• the testing of journals, using data analytics to focus our testing on higher risk journals;<br>• significant accounting estimates relating to the estimates discussed above in respect of NHS revenue recognition and provisioning, capital expenditures and property valuations; and<br>• any unusual transactions or one-off transactions including those with related parties.<br>Our wider response to the risk of fraud is set out in the appendix.<br><br>In considering the risk of management override, we:<br>• assessed the overall position taken in respect of key judgements and estimates;<br>• considered the sensitivity of the financial statements with respect to the achievement of financial performance targets including Financial Sustainability Risk Rating ("FSRR") thresholds;<br>• considered our view on the overall control environment and 'tone at the top'. |
| **Deloitte response** | We have substantially completed our testing of journals and have not found any instances of inappropriate override of control in our sampling.<br>We have not identified any bias in the selection of accounting estimates nor any significant and unusual one off transactions.<br>We have considered the tone at the top and note that there are no concerns we wish to draw to the attention of management. |
| **Inclusion in our audit report** | We do not expect to refer to this risk in our auditor's report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team. |

# Significant audit risks

## Agresso Software Upgrade

| | |
|---|---|
| **Risk update and conclusion** | In our planning report of January 2016 we identified that the migration of the financial data from the old system to the new version of Agresso, if done in an uncontrolled manner, could result in systematic material error which could be pervasive to the entire financial statements and, as a consequence, we concluded that this posed a significant risk of material misstatement.<br><br>As the Committee will be aware the difficulties that the Trust experienced in quarter 3 of 2015/16 following the upgrade to the RiO system meant that the IT department were unable to undertake the planned upgrade work to Internet Explorer which was an essential precursor to the upgrade to the Agresso application. Consequently the upgrade to Agresso was deferred until June 2016 and, therefore, no longer presents a material risk of misstatement to the 2015/16 financial statements.<br><br>We have not, therefore, undertaken focussed audit procedures in respect of the planned upgrade of the Agresso application as part of this audit however we anticipate undertaking such work as part of the audit of the 2016/17 financial statements.<br><br>As the upgrade of the Agresso application is no longer assessed as a material risk to the audit for 2015/16 and it will not be referred to in our audit report. |

# Insights and Recommendations

# Other findings

## Internal control and risk management

ISA 315.12 (UK and Ireland) requires we obtain an understanding of internal control relevant to the audit. It is a matter of the auditor's professional judgment whether a control, individually or in combination with others, is relevant to the audit. We do not test those controls we do not consider relevant to the audit. Below we present a summary of observations and recommendations based on our audit procedures.

| | Observation |
|---|---|
| Fixed Assets | It was noted during the fixed asset testing that there was a lease approaching a break clause that will be taken. Whilst the value of works undertaken at the premises are not significant the Trust has not yet formally inspected the asset to assess whether any costs associated with dilapidations or remediation will be incurred. We recommend that management routinely monitor and quantify the likely future cost of all dilapidations and remedial works for leased assets but particularly those which do not feature in the Trust's medium term estate strategy. |
| CQUIN Income | We have been informed that the Board are not routinely and proactively briefed on the CQUIN hurdles agreed with the commissioners. As these hurdles form an essential part of the Trust's performance monitoring regime it is our opinion that the Board would benefit from an early briefing on the nature of the challenges set and the key risks and mitigations in relation to achieving these so that a balanced view can be taken at the outset of the year. |
| Third Party Assurance | The Trust does not receive an annual service auditor report from Daisy (provision of the Trust's IT infrastructure and associated services) or Servelec (provision of the RiO Electronic Patient Record). The lack of annual service auditor reports from key suppliers means that that Trust has no assurance that key IT general computer controls (information and cyber security, change management, IT disaster recovery and IT operational controls) are operated adequately or sufficiently on the Trust's behalf. Where such controls were not to operate effectively, this may increase the risk of unplanned access or downtime from key Trust systems that impact either clinical care or operational efficiency. We recommend that management ensure that service auditor reports are provided by its key suppliers on an annual basis and review these reports for any deficiencies that might impact the risk profile of the Trust's technology environment. |
| User Administration | There are no periodic, documented reviews of the appropriateness of user access rights to the Windows domain. Where periodic reviews of the appropriateness of user access rights are not performed there is a risk that a user's access rights are inappropriate for their role, and that this may enable them to perform unauthorised transactions or amend data. We recommend that periodic reviews of user access should be performed on the Windows domain, by individuals separate to those who have Administrator rights on the domain. |

# Other findings (continued)

## Internal control and risk management (continued)

| | Observation |
|---|---|
| Leases | Noted that the lease on the decontamination unit expired on 5 May 2016. No new lease has been signed and, at present, no negotiations have begun to secure future access to the site. We understand that the Trust continues to use the asset which continues to have a value reflected in the balance of property plant and equipment. We therefore recommend that the Trust urgently secures continued access to the site commensurate with the overall estate strategy. |
| Instructions to valuer in respect of Chantry and Trinity | The Trust should continue to work with the Valuer to ensure that they are aware of future plans for usage of the Trusts estate. This should include discussion and agreement on assumptions around functional obsolescence and remaining useful economic life. |
| Prior year recommendation noted as remaining outstanding | From our work we noted that the recommendation concerning the need to agree a lease covering the use of the Dales facility remained outstanding. |

# Value for Money

# Value for Money

**Value for Money**

The 2014/15 Audit Code for NHS Foundation Trusts required us to report by exception in our audit report any matters that we identify that indicate the Trust:

- has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; and
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements.

In November 2015, the NAO issued guidance on the 'value for money' work that auditors are required to do. Key elements of change include:

- the definition of 'proper arrangements';
- the guidance (to "strengthen" the guidance) on identification of risk and the work performed to address those risks;
- better alignment the evaluation criteria to the arrangements on which Trust's are already required to report;
- clarifying the options available to auditors when issuing their report; and
- more guidance on relevant sector developments and risks.

**Work performed**

Details of work performed for report by exception risks are detailed overleaf. We have obtained an understanding of the Trust's arrangements for securing "value for money", through a combination of:

- "high level" interviews;
- review of the Trust's draft Annual Governance Statement;
- consideration of the Trust's results, including benchmarking of actual 2015/16 results and the 2016/17 Annual Plan;
- review of the Care Quality Commission's reports on the Trust and the initial communications following the inspection in quarter 4;
- review of Monitor's FSRR and governance risk ratings;
- consideration of the Trust's NHSLA risk rating;
- Consideration of the Trust's Cost Improvement Planning work and arrangements; and
- consideration of the Trust's Information Governance toolkit assessment of Significant Assurance by Internal Audit.

# Value for Money Report by Exception Risks

## Update on matters included in our planning report

In our planning report of January 2016 we noted three areas where our risk assessment concluded that there were potential areas for exception reporting in connection with the delivery of Value for Money. We set out below and on pages 18 and 19 an update on these three areas.

## Contractual relationships in respect of interim senior staff

| | |
|---|---|
| **Nature of Risk** | The Trust has announced that both the Chief Executive and the Director of Finance will be retiring from the Trust and that an interim appointment was made to fill the Director of Finance role.<br><br>The restrictions on consultancy and agency spend is understood to extend to senior staff appointed on an interim basis and so, depending upon the exact nature of the relationship, approval may have to be sought to make the expenditure valid. |
| **Work performed** | • We obtained an understanding of the nature of arrangements through which the Trust contracted for the services of the interim Director of Finance.<br>• We assessed whether external approval was required and obtained evidence that the Trust performed in compliance with necessary approval processes as applicable. |
| **Conclusion** | We are satisfied that the Trust complied with relevant procedures and approval policies in contracting senior employees. |
| **Inclusion in our audit report** | We have not identified any issues which we would need to report in our audit opinion. |

# Value for Money Report by Exception Risks

## Result of the CQC inspection

| | |
|---|---|
| **Nature of Risk** | The Trust was subject to inspection by the CQC in March 2016. Should the CQC identify significant cause for concern then this may have a bearing upon our judgement of the Trust's delivery of value for money. |
| **Work performed** | As the final report from the CQC visit is not available prior to conclusion of the audit, we have undertaken the following procedures to understand the implications:<br>• interviewed senior officers of the Trust subsequent to the visit to understand the high level messages provided; and<br>• reviewed the update included in the annual report in connection with the inspection. |
| **Conclusion** | Our work to date has not identified any specific risks or issues relating to the CQC inspection which would have an impact in respect of Value for Money. |
| **Inclusion in our audit report** | We have not identified any issues which we would need to report in our audit opinion. |

# Value for Money Report by Exception Risks

## Delivery of transformation programme

| | |
|---|---|
| **Nature of Risk** | Whilst the Trust was able to set a surplus budget for the current year our discussions with officers of the Trust indicated that the general opinion is that the 2016/17 budget will be much harder to deliver and will, to an extent, be dependent upon the successful delivery of the transformation agenda. |
| **Work performed** | • In our planning report issued in January 2016 we indicated that we would review the follow up internal audit report on the governance of the transformation programme however this report was removed from the audit plan for the year.<br>• In April 2016, at the Board's request, we undertook a detailed review of the cost improvement plan for 2016/17 with a view to assessing the level of inherent delivery risk in the plan. The results of this review, which were reported to the Board on 28 April 2016, have been considered in respect of this exception risk.<br>• In the report we concluded that, of the £8.5m of cost reduction proposals reviewed, £6m was assessed as being at high risk of non delivery. We set out 21 recommendations to reduce the risk inherent in the plan which management are taking forward. |
| **Conclusion** | Whilst there remains risk to the delivery of the cost reduction plan, review of responses to the recommendations raised leads us to conclude that there is not a significant risk that the arrangements to secure value for money are deficient. |
| **Inclusion in our audit report** | We have not identified any issues which we would need to report in our audit opinion. |

# Our Audit Report

# Our audit report

## We will comment on materiality and scope

In 2014/15 the NHS Foundation Trust Annual Reporting Manual (ARM) adopted the updated reporting requirements of ISA 700 (UK and Ireland) and changed the format of audit opinions to include additional disclosures. Here we discuss the items that we intend to comment on in our audit report. Our audit report includes comment on materiality and scoping, we also comment on the key significant risks which have been the focus of our time and efforts on the audit and our observations on internal control. Further detail of the significant risks we will comment on in our audit report can be found on the following page.

**MATERIALITY**

An explanation of our assessment and application of the concept of materiality is included in the audit opinion. This includes disclosure of the absolute materiality level (£2.27m) and the error reporting threshold to the Audit Committee (£113.5k).

**RISKS**

Detail of the risks we will report on in our audit report are set out on the next slide.

**SCOPING**

We disclose an overview of the audit scope, as set out in our previous communications with you, and how we have responded to the identified risks.

**Other Matters**

Matters we report on by exception including matters specific to FT reporting are set out to the right.

# Our audit report

## Summary of the risks we comment on

In our planning report we explained our risk assessment process and how we selected our significant audit risks. Below is a summary of the significant risks we identified. For each we explain the basis on which we have included or excluded from our audit report. We explain why the risk is relevant within the specific circumstances of the company and clearly document the specific procedures we have performed to address the risk.

The Audit Committee will need to pay particular attention to the risks of material misstatement, calculated materiality and audit scope that we have used. These judgements will be more transparent to all stakeholders in this year's report.

Significant risks: The opinion includes a summary of the risks of material misstatement assessed as being significant to the audit, and that take the greatest audit effort. We have identified these as:

- Revenue Recognition in respect of CQUIN income;
- Property valuations;
- Laura Mitchell House and New Street brought into use; and
- Agresso Software Upgrade.

**Other matters to report by exception:** We are also required to report by exception on the following matters:

- if the Board statement on fair, balanced and understandable is inconsistent with the knowledge we have acquired during our audit;
- if the description of the significant issues considered by the Audit Committee does not appropriately address matters communicated by us to you, the Audit Committee; or
- proper practices have not been observed in the compilation of the financial statements.

**FT specific reports by exception:** Under the Audit Code for NHS Foundation Trusts, we are also required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the ARM, is misleading, or is inconsistent with information of which we are aware from our audit; or
- the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

# Audit Opinion

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| | |
|---|---|
| **Opinion on the financial statements of South West Yorkshire Partnership NHS Foundation Trust** | **In our opinion the financial statements:**<br>• **give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2016 and of the Group's and Trust's income and expenditure for the year then ended;**<br>• **have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and**<br>• **have been prepared in accordance with the requirements of the National Health Service Act 2006.**<br><br>The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cashflows and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts. |
| **Certificate** | We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts. |
| **Going concern** | We have reviewed the Accounting Officer's statement contained on page [xx] that the Group is a going concern. We confirm that<br>• we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and<br>• we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern.<br>However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern. |
| **Our assessment of risks of material misstatement** | The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| Risk | How the scope of our audit responded to the risk |
|---|---|
| **NHS Revenue**<br>There are significant judgments in recognition of revenue from care of NHS service users due to the judgements taken in evaluating the Trust's entitlement to Commissioning for Quality and Innovation (CQUIN) income.<br><br>The total CQUIN premium earned in the year was £3.5m (2015: £4.5m) and represented achievement of 18 performance measures agreed with the Commissioners of the Trust's services. The income earned is included in the balance of 'Income attributed to CCGs and NHS England' disclosed in note 5.1 Income from Activities and recognition is governed by the accounting policy set out at note 1.4.<br><br>In the prior year the risk associated with revenue recognition was focussed upon incremental adjustments to the Trust's revenue contracts arising during the year and particularly where judgement was exercised as to whether, and the extent with which, revenue should be allocated to current or future accounting periods. In the prior year the total of such contract variations totalled only £0.04m and our planning work indicated that the total of such adjustments in the current year was likely to be of a similar magnitude. This led us to conclude that it was unlikely that these incremental adjustment would continue to give rise to a risk of material misstatement. | We evaluated the design and implementation of controls over the negotiation, agreement and monitoring of CQUIN performance targets and the subsequent claiming and recording of earned CQUIN income.<br><br>We tested the recognition of CQUIN income through the year by:<br>• Confirming the amount of CQUIN income available to the underlying contract; and<br>• Challenging on a sample basis the CQUIN income agreed with the commissioners throughout the year and at year end by comparing with internal reporting of performance to confirm consistency between internal and external reporting. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| Risk | How the scope of our audit responded to the risk |
|---|---|
| **Property valuations**<br>The Group holds property assets of £113.5m (2015 £105.8m) within Property, Plant and Equipment at a modern equivalent use valuation. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value.<br><br>The financial statement, at note 12, reflect £0.4m of revaluation gains experienced along with £0.5m of impairments noted and charged to the operating surplus (2015 £2.1m and 1.8m respectively). | We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer.<br><br>We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties with reference to our observations and experience at other similar organisations.<br><br>We assessed whether the valuation and the accounting treatment of the impairment were compliant with the FT ARM, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| Risk | How the scope of our audit responded to the risk |
|---|---|
| **Laura Mitchell House and New Street brought into use**<br>During the year two major capital projects, Laura Mitchell House and New Street, were completed and the assets brought into operational use<br><br>Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards and when to commence depreciation. This judgement particularly crystallises at the point when the asset is brought out of assets under construction and into operational use.<br><br>The value of Laura Mitchell House (£5.3m) and New Street (£3.6m) are included in the transfer from assets under construction of £6.7m disclosed in note 14.1. The impairment of £0.3m disclosed in the same note includes £0.29m relating to these two assets. | • We reviewed management's controls concerning the valuation of assets following the completion of construction works and the accumulation of costs into assets under construction at the year end and tested the designed and implementation of these controls.<br>• We tested, on a sample basis, the accumulation of cost into the balance of assets under construction.<br>• We obtained management's review of the value of completed assets transferring out of Assets Under Construction and challenged management's assumptions and judgements concerning whether impairments should be recognised upon bringing the assets into operational use. Where management have used the work of valuations experts in forming their conclusions we have reviewed the work of the expert utilising our valuations specialists.<br>• We tested the completeness and transparency of the disclosure in the notes to the financial statements. |

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page [x].

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| | |
|---|---|
| **Our application of materiality** | We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.<br><br>We determined materiality for the Group to be £2.27m which is below 1% of revenue and below 2% of Tax Payers' Equity. We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £113,500, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements. |
| **An overview of the scope of our audit** | Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.<br><br>The focus of our audit work was on the Trust, with work performed at the Trust's offices at Castleford and Normanton District Hospital directly by the audit engagement team, led by the audit partner.<br><br>The Trust's subsidiary the South West Yorkshire Partnership NHS Foundation Trust and Other Charitable funds was subject to an independent examination which is not equivalent to a full audit. The Charity represents less than 0.5% of group operating income and assets employed.<br><br>We performed specified audit procedures on the Trust's subsidiary, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the charity to the Group.<br><br>Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| | |
|---|---|
| **An overview of the scope of our audit (continued)** | At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.<br><br>The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.<br><br>Data analytic techniques were used as part of audit testing, in particular to support profiling of populations to identify items of audit interest. These techniques were limited to the area of journal testing.<br><br>All testing was performed by the main audit engagement team, led by the audit partner. |

| | |
|---|---|
| **Opinion on other matters prescribed by the National Health Service Act 2006** | In our opinion:<br><br>• the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006, and<br><br>• the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| **Matters on which we are required to report by exception** | |
|---|---|
| *Annual Governance Statement, use of resources, and compilation of financial statements* | Under the Audit Code for NHS Foundation Trusts, we are required to report to you if, in our opinion:<br>• the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;<br>• the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or<br>• proper practices have not been observed in the compilation of the financial statements.<br>We have nothing to report in respect of these matters.<br>We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| | |
|---|---|
| *Our duty to read other information in the Annual Report* | Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:<br>• materially inconsistent with the information in the audited financial statements;<br>• apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or<br>• otherwise misleading.<br>In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements. |

| | |
|---|---|
| **Respective responsibilities of the accounting officer and auditor** | As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.<br>This report is made solely to the Council of Governors and Board of Directors ("the Boards") of South West Yorkshire Partnership NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed. |

# Audit Opinion (continued)

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

| | |
|---|---|
| **Scope of the audit of the financial statements** | An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report. |

Paul Thomson, ACA (Senior Statutory Auditor)

for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK

[xx] May 2016

# Appendices

the Distinctive audit

# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA 260 (UK and Ireland) to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes the results of our work on key audit judgements.

### What we don't report

- As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

### The scope of our work

- Our observations are developed in the context of our audit of the financial statements.
- We described the scope of our work in our audit plan and the supplementary "Briefing on audit matters" circulated to you previously
- The Insight and Additional assurance findings sections of this report provide details of additional work we have performed alongside the audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP

**Deloitte LLP**

Chartered Accountants

Leeds

26 May 2016

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

# Audit adjustments
## Unadjusted misstatements

The following uncorrected misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland). Uncorrected misstatements decrease profit by £0.3 million, increase net assets by £.6 million, and increase retained earnings by £0.6 million.

| | | Debit/(credit) income statement £000 | Debit/(credit) in net assets £000 | Debit/(credit) prior year retained earnings £000 | Debit/(credit) in Reserves £000 |
|---|---|---|---|---|---|
| **Misstatements identified in current year** | | | | | |
| CQUIN Income | [1] | (309) | 309 | | |
| Agreement of balances | [2] | (220) | 220 | | |
| Revaluation movement | [3] | | 367 | | (367) |
| Creditors | [4] | 155 | (155) | | |
| Aggregation of misstatements individually below £113,500 | | 124 | (124) | | |
| **Impact of errors noted in the prior year relevant to current year** | | 551 | | (551) | |
| **Total** | | **301** | **617** | **(551)** | (367) |

(1) We concluded that CQUIN Income was understated based upon subsequent performance analysis and negotiations with commissioners
(2) Judgemental error noted due to differences between the Trust's reported income values and that of the counterparty, identified through the agreement of balances exercise
(3) Judgemental error noted on revaluation movement in indices between the valuation date (31 December) and the year end (31 March)
(4) Judgemental error caused by extrapolating under accrual noted on our testing of liabilities.

There have also been some reanalysis to the primary statements between accruals and provisions, within property, plant and equipment and staff costs in the consolidation.

# Audit adjustments

## Disclosures

### Disclosure misstatements

The following uncorrected disclosure misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland).

| Disclosure | Summary of disclosure requirement | Quantitative or qualitative consideration |
|---|---|---|
| No uncorrected disclosure misstatements are noted, however we are awaiting a copy of the final accounts to verify that recommended disclosure amendments have been included. | | |

### Other disclosure recommendations

The following omitted disclosures are not material to the financial statements. However their omission could impact the users understanding of the financial statements, or their inclusion is considered best practice. We therefore draw them to your attention.

| Disclosure | Summary of disclosure requirement | Quantitative or qualitative consideration |
|---|---|---|
| No uncorrected disclosure misstatements have been identified. We understand all recommendations put forward have been adopted in the Annual Report. We are currently awaiting for a copy of the final annual report to verify the amendments have been included. | | |

# Fraud responsibilities and representations

## Responsibilities explained

### Responsibilities

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.

### Required representations

We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you have disclosed to us all information in relation to fraud or suspected fraud that you are aware of and that affects the entity or group.

We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

### Audit work performed

- In our planning we identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for the Trust.
- During the course of our audit, we have had discussions with management and those charged with governance to understand the perception of risk and the key controls upon which management and those charged with governance rely. These discussions did not identify any significant deficiencies or risks.
- In addition, we have reviewed management's own documented procedures regarding the fraud and error in the financial statements
- We have considered the findings of the Local Counter Fraud Specialist (LCFS).

# Independence and fees

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

| | |
|---|---|
| Independence confirmation | We confirm that we comply with APB Ethical Standards for Auditors and that, in our professional judgement, we and, where applicable, all Deloitte network firms are independent and our objectivity is not compromised. |
| Fees | Details of the non-audit services fees charged by Deloitte in the period from 1 April 2015 to 31 March 2016 have been presented separately by management. See breakdown on page 40. |
| Non-audit services | In our opinion there are no inconsistencies between APB Ethical Standards for Auditors and the company's policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. |
| Relationships | The following slides provides details of all the relationships (other than the provision of non-audit services which are covered above) we have with South West Yorkshire Partnership NHS FT, its directors and senior management and its affiliates, and other services provided to other known connected parties that we consider may reasonably be thought to bear on our objectivity and independence, together with the related safeguards that are in place. This may include (for example) former partners and staff who have joined the client. |

# Independence and fees

As part of our obligations under International Standards on Auditing (UK & Ireland) and the APB's Ethical Standards we are required to report to you on all relationships (including the provision of non-audit services) between us and the audited entity:

| Relationship / Service provided | Fees (£'000) | Threats to auditor independence | Evidence of informed management | Safeguards in place |
|---|---|---|---|---|
| Review of the Trust's 2015/16 Financial plans | 20 | **Management threat:** We are not proposing to undertake a management function.<br>**Self-review threat:** The non-audit service will not directly generate any figures in the financial statements nor directly design any key financial controls; there is no self review threat.<br>**Self-interest threat:** The nature of the engagement is not material to the audit team or the audit partner. We are disinterested in the outcome of the review.<br>**Advocacy threat:** We are not proposing to act as Trust advocate in any capacity.<br>**Familiarity threat:** We are in compliance with the independence requirements concerning rotation.<br>**Intimidation threat:** Our assessment of management and the tone at the top gives us no reason to doubt they integrity or conduct. | N/A | No safeguards required; the nature of the engagement is entirely complimentary to our role as auditors in concluding upon the Value for Money assessment. |
| "Well led" governance review | 59 | **Management threat:** We are not proposing to undertake a management function and so anticipate no management threat<br>**Self-review threat:** The non-audit service will not directly generate any figures in the financial statements nor directly design any key financial controls; there is no self review threat.<br>**Self-interest threat:** The separation between the audit team and advisory team mitigates any self interest threat as the audit team are disinterested in the outcome of the advisory engagement.<br>**Advocacy threat:** We are not proposing to act as Trust advocate in any capacity; the proposal is to advise not to act.<br>**Familiarity threat:** We are in compliance with the independence requirements concerning rotation. The advisory team is also independent of the Trust.<br>**Intimidation threat:** There is no overlap between the advisory and audit teams and hence any pressure brought to bear on the advisory team will be a matter of indifference to the audit team. | N/A | The principle control is the rigid segregation of audit team and advisory team. There is no overlap between the two nor is the Audit Partner in any way involved in the non audit service proposed. |

# Independence and fees

As part of our obligations under International Standards on Auditing (UK & Ireland) and the APB's Ethical Standards we are required to report to you on all relationships (including the provision of non-audit services) between us and the audited entity:

| Relationship / Service provided | Fees (£'000) | Threats to auditor independence | Evidence of informed management | Safeguards in place |
|---|---|---|---|---|
| Review of RiO upgrade | 15 | **Management threat:** We are not proposing to undertake a management function and so anticipate no management threat<br>**Self-review threat:** The non-audit service will not directly generate any figures in the financial statements nor directly design any key financial controls; there is no self review threat.<br>**Self-interest threat:** The separation between the audit team and advisory team mitigates any self interest threat as the audit team are disinterested in the outcome of the advisory engagement.<br>**Advocacy threat:** We are not proposing to act as Trust advocate in any capacity; the proposal is to advise not to act.<br>**Familiarity threat:** We are in compliance with the independence requirements concerning rotation. The advisory team is also independent of the Trust.<br>**Intimidation threat:** There is no overlap between the advisory and audit teams and hence any pressure brought to bear on the advisory team will be a matter of indifference to the audit team. | N/A | The principle control is the rigid segregation of audit team and advisory team. There is no overlap between the two nor is the Audit Partner in any way involved in the non audit service proposed. |

# Independence and fees

The professional fees earned by Deloitte in the period from 1 April 2015 to 31st March 2016 are as follows:

| | Current year £ | Prior Year £ |
|---|---|---|
| Financial statement audit (including Value for Money conclusion) | 51,672 | 56,000 |
| **Total audit** | 51,672 | 56,000 |
| Review of Trust's financial plans 2014/15 and 2015/16 | 20,000 | 30,000 |
| Review of RiO implementation | 15,000 | - |
| Well led governance review | 59,054 | - |
| **Total assurance services** | **145,726** | **86,000** |
| **Services to the wider group** | | |
| Independent Examination of Charitable Funds | 828 | 2,000 |
| **Total fees** | **146,554** | **88,000** |

# Our approach to quality

## AQR team report and findings

Audit quality is our number one priority. We pride ourselves on our commitment to quality and our quality control procedures. We have an unyielding pursuit of quality in order to deliver consistent, objective and insightful assurance.

In May 2015 the Financial Reporting Council ("FRC") issued its Annual Report on Audit Quality Inspections which provides an overview of its activities of its Audit Quality Review ("AQR") team for the year ended 31 March 2015. It also issued individual reports on each of the four largest firms, including Deloitte. We adopt an open and communicative approach with the regulator and their contribution to audit quality is respected and supported at all levels of our firm. We consider that the AQR's report provides a balanced view of the focus and results of its inspections and its recognition of the emphasis we place on our overall systems of quality control is welcome.

We value the regulator's inspection and comments, and the review performed by the AQR forms an important part of our overall inspection process. We perform causal factor analysis on each significant finding arising from both our own internal quality review and those of our regulators to fully identify the underlying cause. This then drives our careful consideration of each of the FRC's comments and recommendations, as well as findings arising from our own review to provide further impetus to our quality agenda.

**The AQR's conclusion on Deloitte**

"The firm places considerable emphasis on its overall systems of quality control and, in most areas, has appropriate policies and procedures in place for its size and the nature of its client base. Nevertheless, we have identified certain areas where improvements are required to those policies and procedures. These are set out in this report. Our findings relating to reviews of individual audits largely relate to the application of the firm's procedures by audit personnel, whose work and judgments ultimately determine the quality of individual audits. The firm took a number of steps in response to our prior year findings to achieve improvements in audit quality. This included enhanced guidance, technical communications and audit training on the recurring themes. Certain aspects of the guidance could, however, have been issued on a more timely basis."

**2014/15 Audit Quality Inspection Report on Deloitte LLP**

Fifteen of the audits reviewed by the AQR were performed to a good standard with limited improvements required and five audits required improvements. No audits were assessed as requiring significant improvements. The overall analysis of the AQR file reviews by grade for the last five years evidences that, among the largest firms, Deloitte remains at the forefront of audit quality with 68% of audits reviewed by the AQR assessed as good with limited improvements required and, at 5%, the lowest level of audits being assessed as significant improvement required, with none in this category in 2014/15.

We have already taken action to respond to the key themes of the report and will continue to undertake further activities to embed the changes into our practice.

# Our approach to quality

| Areas identified for particular attention | How addressed in our audit |
|---|---|
| Ensure that audit teams focus more on the audit of valuations and accounting estimates, including appropriate challenge of management and enhancing the quality of audit evidence relating to the key assumptions. | This is a significant audit risk and is addressed in the significant risk section of this paper. |
| Improve the testing of management reports and other system generated information to obtain assurance on its reliability for audit purposes. | We have re-emphasised the requirement for testing system generated reports and management reports as part of our audit procedures to provide additional assurance of reliability and this has been a key aspect of audit team training. |
| Improve the testing of controls, including the assessment of the effectiveness of monitoring controls and how identified weaknesses in IT controls are addressed. | We have evaluated the design and implementation of controls relevant to the financial reporting and significant risk areas in line with our planning report and as detailed in the significant risk section of this report. |
| Ensure that the firm's audit reports accurately describe the audit procedures performed to address the identified risks. | Our audit report has been tailored to describe the work we have done in each of the areas set out in the significant risk and value for money sections of this report. |
| Ensure that audit planning discussions are held with Audit Committees on a more timely basis to enable their input to be reflected appropriately in the audit plan. | We communicated our Audit Plan at the Audit Committee meeting held on 2nd of February 2016 thereby enabling the Audit Committee to input into the audit plan. |
| Ensure more timely development of enhanced guidance when addressing internal and external quality review findings. | While this does not directly affect our audit plan, we will ensure that our engagement team always utilise the most recent expert advice and guidance. |

Deloitte.

Deloitte.

South West Yorkshire Partnership NHS Foundation Trust

# Findings and Recommendations from the 2015/16 NHS Quality Report External Assurance Review

## Final Report

the Distinctive audit

**Draft Report: May 2015**

Deloitte.

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Council of Governors
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

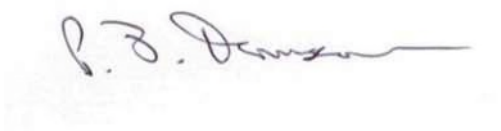
18 May 2016

Dear Sirs

We have pleasure in setting out in this document our report to the Council of Governors of South West Yorkshire Partnership NHS Foundation Trust on our external assurance review of the 2015/16 Quality Report.

This report updates the findings previously communicated to the Audit Committee in March 2016 and, in order to gain a full understanding of the issues set out, this document should be read in conjunction in with that earlier report which has been included as Appendix A to this report.

Yours faithfully



**Paul Thomson**
Deloitte LLP
Senior Statutory Auditor

# Contents



***This report sets out the findings from our work on the 2015/16 Quality Accounts.***

***We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review***

# Executive Summary

# Executive Summary

**Status of our work**

We have substantially completed our review, including validation the two mandatory indicators (Access to Crisis Resolution Home Treatment team and Delayed Transfer of Care) and testing of the local indicator (Care Plans).

The testing of the local indicator was in February. We reported in March that we identified significant issues with the reporting of this indicator and that action was required to determine how best to meet the Trust's reporting intentions. The detail of our findings were set out in pages 8 to 10 of our interim report which is reproduced as Appendix A to this document.

The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2015/16".

In response to the growth of performance indicators across the NHS, we have developed a framework of considerations for evaluating data quality. We have used this framework in evaluating our findings and the recommendations we have raised.

We are waiting for an updated version of the quality report which we understand will address the minor reocmmendations that we have raised for correction.

**Context**

- Governance Risk Rating: Green
- During 2015/16 the Trust was inspected by the CQC; the results of the inspection are still awaited.

| | 2015/16 | 2014/15 |
|---|---|---|
| Length of Quality Report | 70 pages (draft version) | 57 pages |
| Quality Priorities | 7 | 7 |
| Future year Quality Priorities | 7 | 7 |

**Scope of work**

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in Monitor's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected Access to Crisis Resolution Home Treatment Team and Delayed Transfer of Care (DTOC) as its publically reported indicators – the alternative was 7 day follow up (CPA).
  - For 2015/16, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected Care Plan implementation as its local indicator.
- The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the Crisis Gatekeeping and DTOC indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
- Provide a report to the Council of Governors, setting out our findings and recommendations for improvements for the Quality Report and for the indicators tested: access to crisis resolution/home based treatment teams, DTOC and Care Plan implementation.

# Executive Summary (continued)

## Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have substantially completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

| | Overall conclusion |
|---|---|
| **Content**<br>Are the Quality Report contents in line with the requirements of the Annual Reporting Manual? | G<br>[Subject to correction] |
| **Consistency**<br>Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)? | G<br>[Subject to receipt of outstanding feedback] |

## Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

Monitor requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators and one local indicator. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Guidance for External Assurance on Quality Reports 2015/16".

| | Access to Crisis HBT | DTOC | Local Indicator[1] |
|---|---|---|---|
| **Accuracy**<br>Is data recorded correctly and is it in line with the methodology. | G | B | R |
| **Validity**<br>Has the data been produced in compliance with relevant requirements. | G | G | n\a |
| **Reliability**<br>Has data been collected using a stable process in a consistent manner over a period of time. | G | G | R |
| **Timeliness**<br>Is data captured as close to the associated event as possible and available for use within a reasonable time period. | G | G | R |
| **Relevance**<br>Does all data used generate the indicator meet eligibility requirements as defined by guidance. | G | G | R |
| **Completeness**<br>Is all relevant information, as specific in the methodology, included in the calculation. | G | G | R |
| **Recommendations identified?** | × | ✓ | ✓ |
| **Overall Conclusion** | G<br>Unmodified Opinion | B<br>Unmodified Opinion | No opinion required |

G No issues noted  B Satisfactory – minor issues only  A Requires improvement  R Significant improvement required

[1] See Interim Report pages 8 to 10 reproduced as Appendix A to this Report

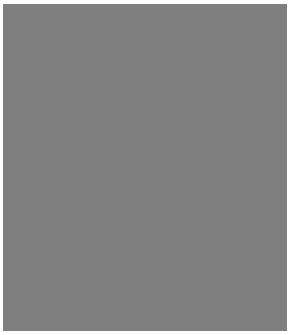
# Content and consistency findings

# Content and consistency review findings

## The Quality Report meets regulatory requirements

**The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.**

**Our work is based around reviewing content against specified criteria and considering consistency against other documentation. Although outside the formal scope of our work, we have also made recommendations to management to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report, based upon the points identified in our NHS Briefing on Quality Accounts from our wide experience.**

| Key questions | Assessment | Statistics |
|---|---|---|
| • Is the length and balance of the content of the report appropriate? | G | Length 70 pages |
| • Is there an introduction to the Quality Report that provides context? | G |  |
| • Is there a glossary to the Quality Report? | G | |
| • Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)? | G | More than 3 indicators in each of the three areas |
| • Has the Trust set itself SMART objectives which can be clearly assessed? | G |  |
| • Does the Quality Report clearly present whether there has been improvement on selected priorities? | G | |
| • Is there appropriate use of graphics to clarify messages? | G | |
| • Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)? | G | |
| • Is the language used in the Quality Report at an appropriate readability level? | A | Flesch Reading Score: 35 |

G No issues noted  B Satisfactory – minor issues only  A Requires improvement

### Deloitte view

The draft quality account included a small number of points which were inconsistent with the requirements and which have been communicated to management, These have been corrected the in the report issued to the Audit Committee.

We have used the Flesch Readability Software to calculate a score of 35 (2015 34) which is at the lower end of the readability spectrum (1-100) with 60-70 being ideal. To improve the readability score the Trust should seek to reduce the average number of syllables per word used in the Quality Account.

# Performance indicator testing

# Access to crisis resolution home treatment team

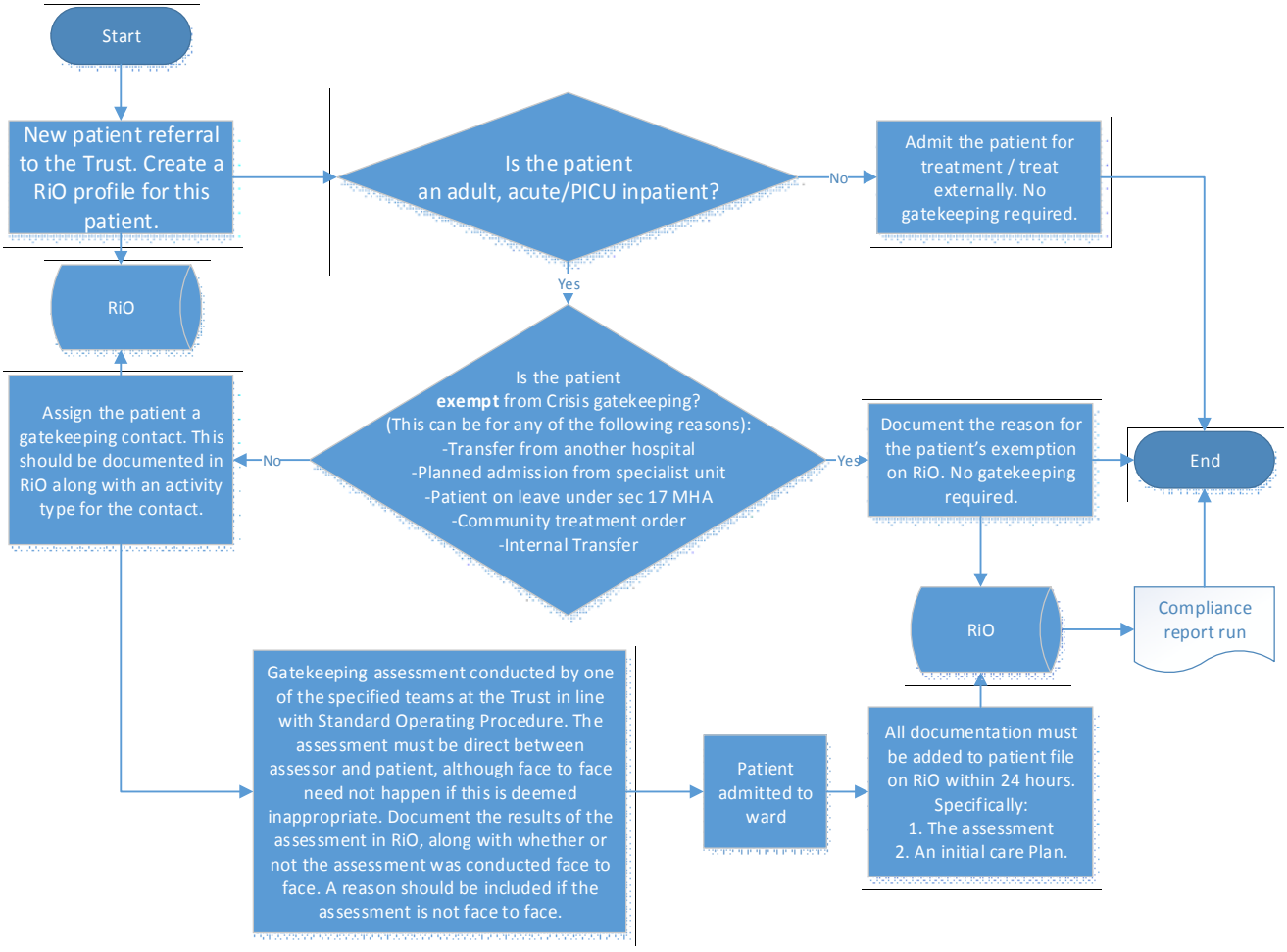
## We found that the indicator was not materially mistated

| | Trust reported performance | Target | Overall evaluation |
|---|---|---|---|
| 2015/16 | 96.4% | 95% | G |

## Indicator definition and process

**Definition:** "The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams."

Crisis Resolution / Home Treatment Services form part of the drive to ensure inpatient care is used appropriately and only when necessary, with service users being treated in the community setting, where possible. They are to provide a 'gateway' to inpatient care and are deemed to have 'gatekept' an admission if they have assessed the service user before admission and they were involved in the decision making process, which resulted in full admission.

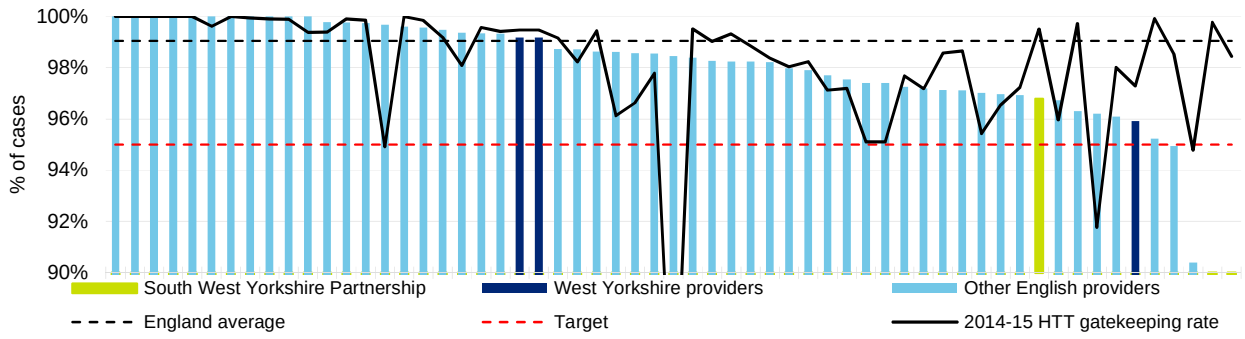


# Access to crisis resolution home treatment team (continued)

## National context

The chart below shows how the Trust compares to other organisations nationally for 2014/15, the latest national data available.

**Inpatient admissions with access to Crisis Resolution/Home Treatment teams - 2015-16**




Source: Deloitte analysis of Health and Social Care Information Centre data

## Approach

- We met with the Trust's leads to understand the process from identifying that a service user should have access to the crisis resolution team to the overall performance being included in the Quality Report.
- We recalculated the indicator using data provided by the Trust.
- We evaluated the design and implementation of controls through the process. We used analytical procedures to identify whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on.
- We selected 3 samples of 25 from 1 April 2015 to 31 March 2016 of service users assessed by the Home Treatment Team, users who were not assessed, and users who were classed exempt from the gatekeeping process.

## Findings

- Our testing revealed a small number of errors which had an immaterial impact on the reported performance, in view of this we did not extend our testing.

# Delayed transfer of care

## Improvements are required with regards to recording of date ready for discharge

| | Trust reported performance | Target | Overall evaluation of our work |
|---|---|---|---|
| 2015/16 | [o/s]% | <7.5% | B |

### National context

There is no national data available for this indicator.

### Indicator definition and process

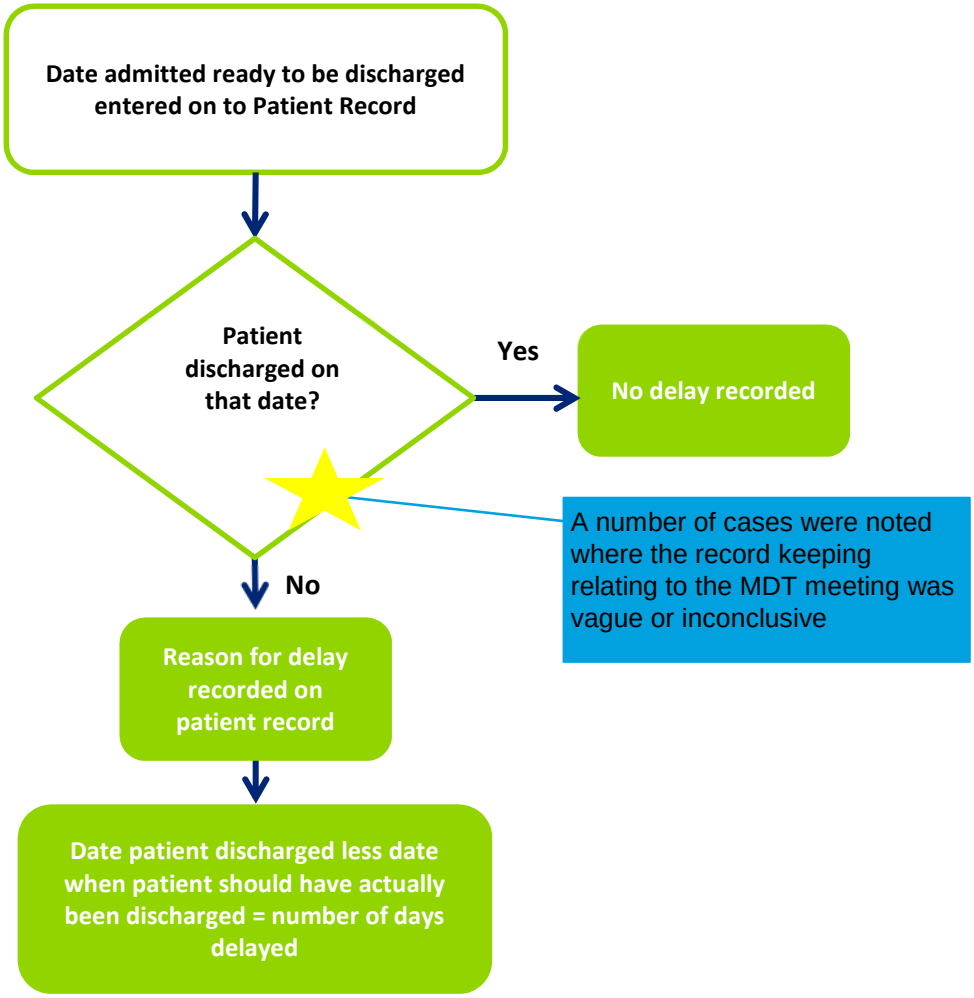
**Definition:** "The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

[a] a clinical decision has been made that the patient is ready for transfer AND

[b] a multi-disciplinary team decision has been made that the patient is ready for transfer AND

[c] the patient is safe to discharge/transfer."

This indicator measures the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and mental health trusts must ensure, with primary care organisations and social services that people move on from the hospital environment once they are safe to transfer.



# Delayed transfer of care (continued)

## Approach

- We performed a walkthrough of the process the Trust has in place to capture and record data.
- We recalculated the indicator using data provided by the Trust.
- We tested a sample of 29 items from the population of delayed cases (including those included and excluded from the indicator) and a further sample of 25 items where no delay was recorded.

## Findings

- We are still waiting for the Trust to provide their calculation of the indicator (hence the indicator is stated as o/s above)
- In a small number of cases the recording of the commencement of the delay was vague and required corroboration by other means however this represented a clear improvement on the prior year findings.

# Recommendations

# Recommendations for improvement

| Indicator | Deloitte Recommendation | Management Response |
|---|---|---|
| DTOC<br>Medium Priority | **Date recording in patient notes**<br><br>Further improvemetns are required in the capture of MDT decisions that a patient is ready for discharge. The need to keep a complete record of these decisions should be re-emphasised to the ward teams. | As a Trust we are confident that the vast majority of clinical teams are clear about the need to record the MDT decisions accurately. In fact this audit identified only five cases (20%) where the records were vague or inconclusive. We will of course ensure all clinical teams are reminded of our standards for DTOC recording. |
| | **Validity of Methology**<br>Steps should be taken to eliminate the risk of self review and bias in the selecting and auditing of cases. Key improvements required include:<br>• Audits to be completed by a member of staff independent of the reporting clinical team;<br>• Samples to be selected independently of the reporting clinical team;<br>• Sample sizes should be set at 10 items per area and returns either below or in excess of 10 items should be challenged; and<br>• Returns should be gathered from all teams and nil returns challenged. | |
| Care Plan within 28 days.<br>Medium Priority | **Maintenance of audit trail**<br>Management should take steps to ensure that the audit trail from indicator to underlying records is captured and preserved to permit checking and validation of the reported performance. | **Responsible Officer**:<br>**Timeline**: |
| | **Timeliness of performance reporting**<br>The data upon which performance was to be reported was almost 12 months old, management should either:<br>• alter the timing of the evaluation exercise to ensure that the performance being reported is up to date, or<br>• make the age of the reported performance clear in public reporting. | **Responsible Officer**:<br>**Timeline**: |
| | **Clarity of decision making**<br>The Trust should ensure that, as part of the data collection exercise, sufficient evidence is captured by the assessor to allow a similarly skilled individual to reach the same conclusion without further guidance of instruction. Key information to capture includes the evidence considered, the judgements made and the conclusions drawn. | **Responsible Officer**:<br>**Timeline**: |

# Update on prior year recommendations

## Our prior year recommendations have been updated.

| | Deloitte Recommendation | Management provided update |
|---|---|---|
| 7 day follow up | **Contact date**<br>Management should consider whether, in the interests of absolute accuracy of the data, controls should be put in place to improve the accuracy of recording of the follow up date. | |
| DTOC | **Date recording in patient notes**<br>Improvements should be made in recording of date ready for discharge / commencement of delay to discharge. | |
| Waterlow assessment | **Timing of assessment**<br>The definition of this, and all locally determined indicators, should be closely and precisely and the definitions shared with relevant stakeholders and interested parties. | |

# Responsibility statement

# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under Monitor's Audit Code to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

### What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

### The scope of our work

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary "Briefing on audit matters" circulated to you previously.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**
Chartered Accountants

May 2016

# Appendix A Interim Report

Deloitte.

# South West Yorkshire Partnership NHS Foundation Trust

## Update on the 2015/16 NHS Quality Indicators

## External Assurance Review

## Interim Report

the Distinctive audit

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Audit Committee
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

28 March 2016

Dear Sirs

We have pleasure in setting out in this document our interim report to the Audit Committee of South West Yorkshire Partnership NHS Foundation Trust on our external assurance review of the 2015/16 NHS Quality indicators

Yours faithfully

**Paul Thomson**
Deloitte LLP
Senior Statutory Auditor

## Appendix A – Interim Report

# Contents



***This report sets out the interim findings from our work on the 2015/16 Quality Indicators.***

***We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review***

# Executive Summary

# Executive Summary

## Our interim work is substantially complete and a number of observations have been raised.

**Status of our work**

We have substantially completed our review, of the two mandatory indicators for the first three quarters of the year (Delayed Transfer of Care and Access to Crisis Resolution Home Treatment Team) and testing of the local indicator (percentage of patients for whom a care plan has been correctly recorded in line with the time limits applicable to the area of the business).

**Scope of work**

The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2014/15". The guidance for 2015/16 has yet to be finalised however we do not expect any significant changes to the requirements relating to the testing of Mental Health quality indicators. Once the guidance is released we will confirm that the scope of our work remains in compliance with the guidance.

In respect of the quality indicators we are required to:

- Perform sample testing of three indicators.
  - The Trust has selected Delayed Transfer of Care (DTOC) and the Access to Crisis Resolution Home Treatment Team, as its publically reported indicators. The third alternative, 7 day follow up for patients on CPA, was tested in 2014/15.
  - For 2015/16, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. For 2015/16 the Council has selected the percentage of patients for whom a care plan has been correctly recorded in line with the time limits applicable to the area of the business as its local indicator.
- The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- This report sets out the finding and observations reached through testing the mandatory indicators (DTOC and Crisis) for the first three quarters of the year and the testing of the local indicator.

In response to the growth of performance indicators across the NHS, we have developed a framework of considerations for evaluating data quality. We have used this framework in evaluating our findings and the recommendations we have raised.

**Findings**

Through our work on the mandatory indicators we have identified a small number of minor errors or points for improvement however the impact on the indicator is not considered to be significant and, for DTOC which was tested in 2014/15, this represents an improvement in performance

Our testing of the local indicator has revealed a number of significant issues concerning both the methodology in place for the collation of the data and the completeness and accuracy of the resulting data set. We recommend that management take urgent action to determine how best to meet reporting intentions in respect of this indicator.

# Performance indicator testing

# Delayed Transfer of Care

## Improvements are required with regards to recording of date ready for discharge

### National context

There is no national data available for this indicator.

### Indicator definition and process

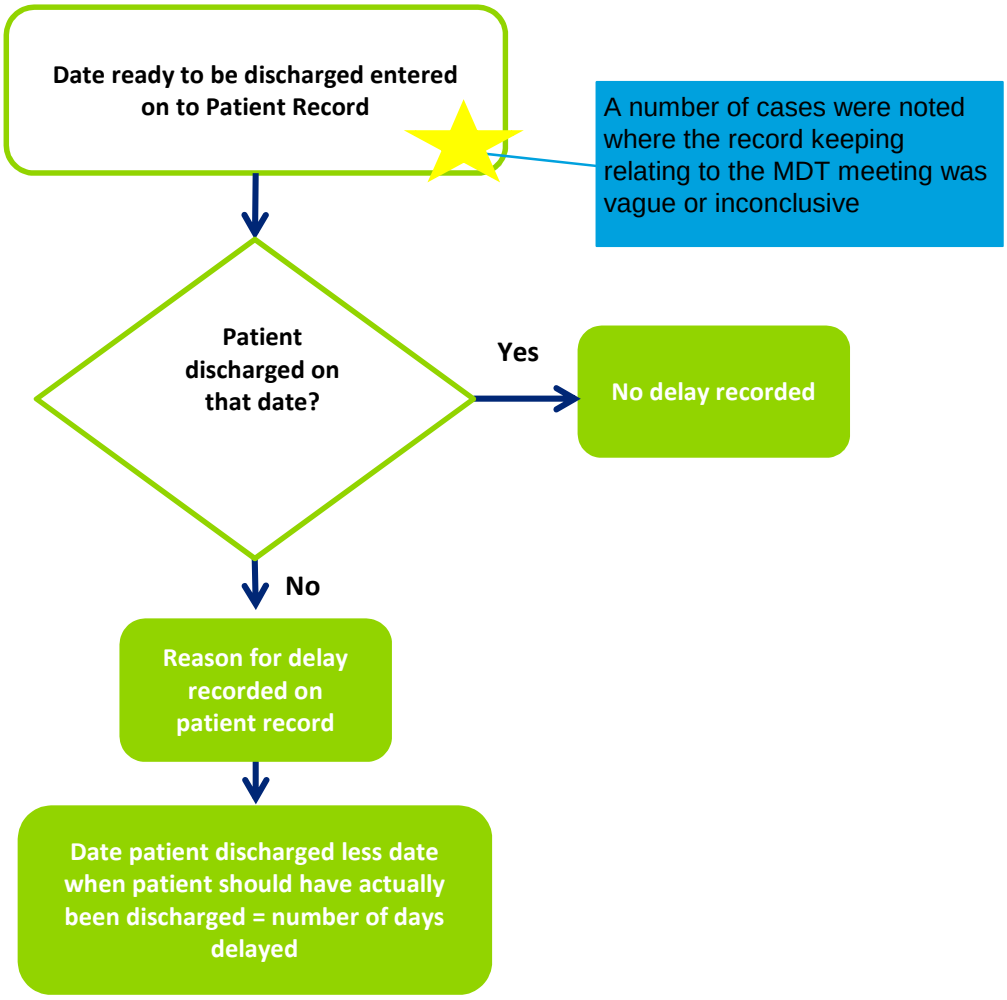
**Definition:** "The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

[a] a clinical decision has been made that the patient is ready for transfer AND

[b] a multi-disciplinary team decision has been made that the patient is ready for transfer AND

[c] the patient is safe to discharge/transfer."

This indicator measures the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and mental health trusts must ensure, with primary care organisations and social services that people move on from the hospital environment once they are safe to transfer.



# Delayed transfer of care (continued)

## Approach

- We performed a walkthrough of the process the Trust has in place to capture and record data.
- We have tested a sample of 48 items from 1 April 2015 to 31 December 2015 which were stratified as follows;
    - 24 items were selected at random from those cases which resulted in a reportable delay at the situation report (SitRep) date,
    - A further sample item was selected to ensure that all cases which were recorded as discharged in the 24 hours preceding the SitRep date were selected (being the population that could have been deliberately or accidently manipulated to avoid reporting a delay),
    - A further 3 items were selected to capture all cases where the discharge date was the Monday following the SitRep date (a Monday discharge date being considered potentially indicative of poor record keeping),
    - 19 items were selected from the population where no delay was recorded to ensure that these did not contain any omitted delayed discharges, and
    - A further item was randomly selected which did not fall into the above categories.

## Findings

- In 4 cases there was insufficient evidence recorded on RiO to confirm that a delay had begun (i.e. there was no evidence of the MDT meeting to agree a discharge date). In 3 of these cases we were able to corroborate the commencement of the delay to offline returns from the ward areas however, for the fourth case, this was not possible as the Trust has moved away from offline reporting in favour of RiO based reporting. Consequently, in respect of this one item we are unable to conclude our testing.
- In two cases there remains information outstanding to support our conclusions.

**Deloitte View:**

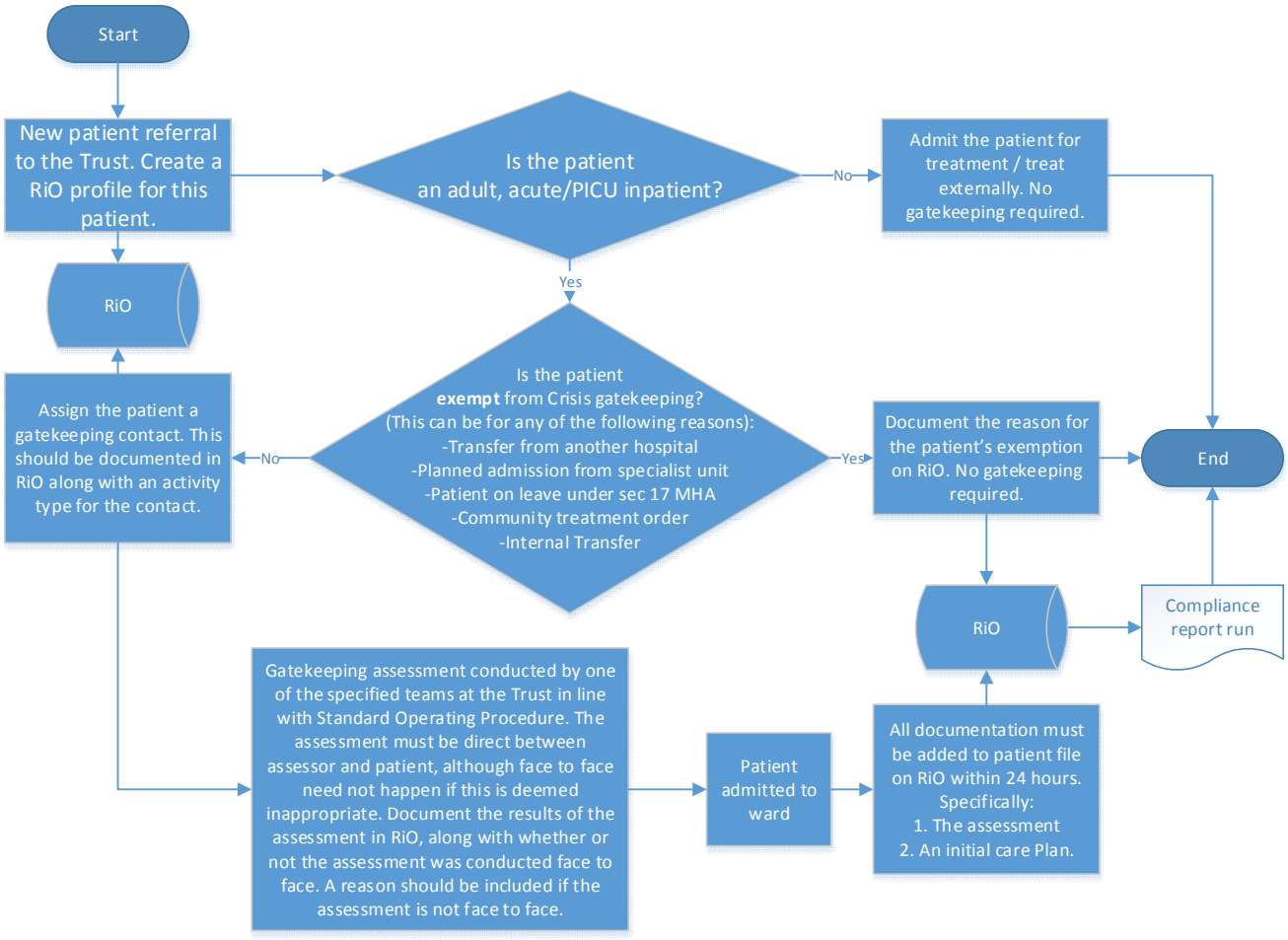
In 4 of the cases sampled we noted that there was lack of evidence regarding the precise date on which the delay began. Whilst this is an improvement on our 2014/15 findings when we detected 9 items where there was insufficient evidence, it remains the case that there is scope for improvement to the accuracy and reliability of the data upon which the Trust is calculating its performance.

# Access to Crisis Resolution Home Treatment Team

## Indicator definition and process

Definition: “The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams.”

Crisis Resolution / Home Treatment Services form part of the drive to ensure inpatient care is used appropriately and only when necessary, with service users being treated in the community setting, where possible. They are to provide a ‘gateway’ to inpatient care and are deemed to have ‘gatekept’ an admission if they have assessed the service user before admission and they were involved in the decision making process, which resulted in full admission.



# Access to crisis resolution home treatment team (continued)

## Approach

- We performed a walkthrough of the process the Trust has in place to capture and record data.
- We have tested a sample of 57 items from 1 April 2015 to 31 December 2015 which were stratified as follows;
    - 19 items were selected from the population recorded as being effectively gatekept
    - 19 items were selected from the population recorded as not being effectively gatekept
    - 19 items were selected from the population of exempt cases.

## Findings

- An error was noted in respect of a single case which had been listed as excluded from the need to be gatekept. In this case, although the case was excluded, scrutiny of the underlying records indicated that it should have been included in the indicator and that the case had been effectively gatekept (i.e. it should have been included as a compliant case).

**Deloitte View:**

In one of the items sampled from the population of exempt cases it was found that the case should not have been recorded as exempt and that it had actually been effectively gatekept. The impact of the noted error improved the reported performance to Quarter 3 by a trivial amount.

# Local Indicator- Care Planning

## The Trust should consider whether the indicator is fit for public reporting.

| | Trust reported performance | Target |
|---|---|---|
| 2015/16[2] | 97.5% | 100% |

### Indicator definition and process

**Definition:** Are all patients who are being treated under Care Programme Approach (CPA) subject to a documented care plan within 28 days of presentation.

### National context

This is a local indicator and therefore there is no relevant comparator information

### Approach

- We met with the Trust's leads to understand the process.
- We undertook a walkthrough of the process as documented
- We reperformed the calculation of the indicator based upon the data extracted from the Trust's information systems
- We undertook substantive testing as follows;
    - We reviewed the data held against teams from whom data was expected to confirm completeness of the data gathering exercise,
    - We tested a sample of 25 items which were recorded as "Null" to determine on what grounds they had been excluded from the indicator,
    - We tested 20 items from the population declared as being in receipt of a care plan within the timescales, and
    - We tested 5 items which were declared as not being in receipt of a care plan with the timescales.

### Findings

We have concluded that the data supporting this indicator is not fit for purpose and, as such, the Trust must urgently consider how best to meet its public reporting intentions with regard to this indicator. The issues noted during our testing are;

- When considering the completeness of the population presented for audit we identified 11 teams (out of a total of 85 teams) who were contacted for data but who did not make a return or feature in the underlying data. Consequently the Trust can have no confidence that the data used to calculate the indicator is complete.
- The instructions issued by the Trust to each area was to test 10 cases and report the findings on each. Scrutiny of the underlying data indicates that many of the areas tested more than 10 cases (22 teams) or less than 10 cases (12 teams) meaning that of the 74 teams who have made a return is appears that 34 have failed to follow the instructions.
- The teams are permitted to select their own 10 items for review and testing. Given that they are reporting their own performance and it can reasonably be expected that reporting non-compliance would not be to the teams' advantage the Trust's approach introduces a risk of bias in the selection of samples towards compliant cases and, as such, cannot be relied upon as a methodology for fair reporting of performance.

[2] The Trust calculates this indicator based upon a snap shot audit of clinical record keeping at a point in time during the year.

# Local Indicator- Care Planning (continued)

**Findings (continued)**

- Once our samples were selected it was found that most of the audit trail from the date used to calculate the indicator had either been lost or destroyed, consequently there was no way for the audit team to consistently trace performance data back to underlying records and, based on the underlying records, confirm reported performance.
- For a sample cases where the audit trail could be confirmed a further sample was selected to determine whether, on this unrepresentative sample basis, the underlying data supported the reported performance. Of the 25 items sample we found:
  - 9 items appeared to be correctly classified; and
  - 16 items were inconclusive due to lack of evidence.
- Finally, when considering the timeliness of the data, the period addressed by the data actually falls outside the year 1 April 2015 to 31 March 2016 as the survey was completed in January/February 2015. Due to operational pressures the same record keeping audit has not been completed in January/February 2016 and has, instead, been slipped into the first quarter of 2016/17. This means that the year 2015/16 will not be subject to audit at all and that the Trust's current intention is to publish data which, by the time the quality report is released, will be about 16 months old. The Trust should consider whether:
  - the information needs of the users of the quality report are best served by presenting data that is significantly out of date; and
  - the Trust is comfortable with the implication that the records in 2015/16 will not be subject to audit at all.

**Deloitte View:**

The indicator as calculated is based upon data that appears to be fundamentally flawed, based upon an unreliable methodology and incapable of rectification. The Trust should consider how it can meet its reporting intentions in view of the clear limitations of the data and the underlying methodology.

# Local Indicator- Care Planning (continued)

**Initial Management Response:**

Whilst a formal response will be provided and incorporated into the final report management's initial responses to the points raised as set out below

1. It is not clear why some teams may not have participated at this time but for future Clinical Record Keeping audits we have logged the teams and will ensure wherever possible that there is 100% response.
2. Although we ask for 10 cases, this is a minimum response rate and we have no problem with a bigger sample – this is more appropriate for teams with very large caseloads. For the teams where there were less than 10, this may be due to the fact that they had a very small caseload or this was the only number available that fitted the other criteria.
3. We acknowledge this and have plans in place through our recording system (point 1) to ensure that this does not occur in future audits. In future, teams will be asked to audit the records from other teams.
4. We acknowledge that the audit trail has been lost and had not realised that this was happening until the Deloitte audit. As we are always keen to ensure anonymity of data we were not aware that staff undertaking the audit were not keeping a record of the sample audited. We have now amended the survey monkey tool so that it is impossible to complete the audit tool without a patient identifier i.e. RiO or SytmOne number on each response.
5. We are aware that there were some problems with RiO at the time that the auditor and the member of staff were undertaking this. The presence of Care plans and reviews are an issue of concern and part of the RiO implementation plan and action log.
6. In summary, the data that has been audited has come from last year's clinical record keeping audit. There is a plan to roll out the re-audit across the trust. Whereas this did commence in January 2016 with the mental health wards and teams, unfortunately due to ongoing problems with RiO and the access to information it was agreed that the process should be delayed. This process will be reinstated in Q1 16/17 with reference to the Deloitte report findings to ensure this is a robust and reliable process.

# Responsibility statement

# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our interim report is designed to help the Audit Committee discharge their governance duties. We will complete our work on the quality indicators as part of the final audit visit and will, at the same time, review the quality report for content and consistency. Based upon the work reported here and the work planned to be carried out subsequently we will form our overall conclusions on the quality report and provide the Council of Governors and Management with our final report and limited assurance report. In this way we will discharge our duties under the Monitor Code.

### What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

### The scope of our work

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary "Briefing on audit matters" circulated to you previously.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**
Chartered Accountants

March 2016

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**Member of Deloitte Touche Tohmatsu Limited**

## APPENDIX 2

## SWYPFT Response to Findings & Recommendations from the 2015-16 NHS Quality Report External Assurance Review.

| Indicator | Deloitte Findings/ Recommendations | Management Response | Responsible officer / time frame |
|---|---|---|---|
| **Mandated item** | | | |
| **DTOC** | **Date recording in patient notes**<br>Further improvements are required in the capture of MDT decisions that a patient is ready for discharge. The need to keep a complete record of these decisions should be re-emphasised to the ward teams | We will ensure all clinical teams are reminded of our standards for DTOC recording. | Assistant Director of Nursing, Professions and Governance.<br><br>June 2016 |
| **Local indicator- care plan within 28 days** | | | |
| **1.** | **Validity of Methodology**<br>Steps should be taken to eliminate the risk of self- review and bias in the selecting and auditing of cases. Key improvements required include:<br>• Audits to be completed by a member of staff independent of the reporting clinical team;<br>• Samples to be selected independently of the reporting clinical team;<br>• Sample sizes should be set at 10 items per area and returns either below or in excess of 10 items should be challenged; and<br>• Returns should be gathered from all teams and nil returns challenged | We will review the methodology for the clinical record keeping audits and consider the points suggested.<br><br>We will update our clinical record keeping audit guidance to ensure teams are clear of the methodology. | Assistant Director of Nursing, Professions and Governance.<br><br>June 2016 |
| **2.** | **Maintenance of audit trail**<br>Management should take steps to ensure that the audit trail | We acknowledge that this is correct and | Assistant Director of |

| | | | |
|---|---|---|---|
| | from<br>indicator to underlying records is captured and preserved to permit checking and validation of the reported performance. | we had not realised that this was happening until the Deloitte audit. We have amended the survey monkey tool so that it is impossible to complete the audit tool without a patient identifier i.e. RiO or SytmOne number on each response. | Nursing, Professions and Governance.<br><br>Complete April 2016 |
| **3.** | **Timeliness of performance reporting**<br>The data upon which performance was to be reported was almost 12 months old, management should either:<br>• alter the timing of the evaluation exercise to ensure that the performance being reported is up to date, or<br>• make the age of the reported performance clear in public reporting. | The data that was audited came from an audit in February 2015 (2014-15 financial year). At the start of the audit it was agreed, with Deloitte, that as the CRK audit report was finalised within 2015/16 it would be suitable to test.<br><br>We have made the age of the performance data clear in the Quality Account report for 2015-16. | Assistant Director of Nursing, Professions and Governance.<br>Complete May 2016 |
| **4.** | **Clarity of decision making**<br>The Trust should ensure that, as part of the data collection exercise, sufficient evidence is captured by the assessor to allow a similarly skilled individual to reach the same conclusion without further guidance of instruction. Key information to capture includes the evidence considered, the judgements made and the conclusions drawn. | This will be taken into consideration when improving the methodology of the clinical record keeping audits. | Assistant Director of Nursing, Professions and Governance.<br><br>June 2016 |

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# Trust Board 28 June 2016
# Agenda item 7.2

| | |
|---|---|
| **Title:** | **Corporate Governance Statement 2016/17** |
| **Paper prepared by:** | Director of Corporate Development |
| **Purpose:** | To provide assurance to Trust Board that it is able to make the required self-certifications as part of the governance statements required to inform the submission of the annual plan to Monitor. |
| **Mission/values:** | The Trust's annual plan describes how the Trust will meet its mission and adhere to its values. |
| **Any background papers/ previously considered by:** | Trust Board received and approved the operational plan for 2016/17 on 29 March 2016. The Annual Governance Statement was approved by the Audit Committee on 23 May 2016. |
| **Executive summary:** | Background<br>As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance statements under its licence conditions, the Risk Assessment Framework and the Health and Social Care Act 2012. Trust Board is required to make self-certifications in relation to:<br><br>1. systems for compliance with licence conditions (general condition 6 of the NHS Provider Licence);<br>2. availability of resources (continuity of services condition 7 of the NHS Provider Licence);<br>3. Corporate Governance Statement (Risk Assessment Framework);<br>4. Academic Health Science Centre and governance arrangements for these (appendix E of the Risk Assessment Framework); and<br>5. training of governors (s151(5) of the Health and Social Care Act 2012).<br><br>A self-certification against item 1 was approved by Trust Board in April 2016 and made on behalf of Trust Board by the Chair and Chief Executive by the required date of 31 May 2016. Item 3 was included in the financial return to NHS Improvement to support the Trust's operational plan on 18 April 2016. Items 3 and 5 are required by 30 June 2016 and are the subject of this paper. Item 4 is not applicable to this Trust at the current time.<br><br>Corporate Governance Statement<br>The attached paper sets out the statements Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is advised that it is able to make the required self-certification in relation to the Trust's Corporate Governance Statement.<br><br>Training of governors<br>Trust Board is required to declare that it is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.<br><br>Starting in 2013, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The |

| | |
|---|---|
| | Trust supports the training and development of governors in a number of ways.<br>- There is an annual session to evaluate the contribution and work of the Members' Council, facilitated by an external facilitator and includes a self-assessment by governors, both individually and collectively, of their contribution and effectiveness. New members also participate in the annual evaluation of Members' Council activity, which enables them to learn from the experience of others.<br>- The Trust offers 1:1 support and 'buddying' as part of the induction programme for Governors.<br>- Attendance at national GovernWell training modules is also encouraged and the Trust facilitates attendance.<br>- Each governor has an induction meeting with the Chair and a review meeting to discuss individual performance and training and development needs.<br>- The Trust arranges briefing sessions for governors in areas identified where it is felt more in-depth and detailed knowledge would be beneficial. This includes finance and performance, and Trust services.<br>- Most formal Members' Council meetings include a discussion item, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. Examples include child and adolescent mental health services, the Trust's strategic approach and sustainability, and transformation of Trust services.<br><br>In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from governors at two levels.<br><u>Required</u><br>- Attendance at a minimum of three out of four formal Members' Council meetings.<br>- Attendance at the annual evaluation session.<br>- 1:1 introductory meeting with the Chair.<br>- Annual review meeting with the Chair.<br>- Attendance at the annual members' meeting.<br><u>Desirable</u><br>- Attendance at the Foundation Trust Network's GovernWell modules.<br>- Attendance at Trust Board meetings.<br>- Attendance at training and development sessions organised by the Trust.<br>- Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee).<br><br>From the assurance provided, Trust Board is advised that it is able to make the required self-certification in relation to training of governors. |
| **Recommendation:** | **Trust Board is ASKED to CONFIRM that it is able to make the required self-certification in relation to the Corporate Governance Statement and training for governors and to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance.** |
| **Private session:** | Not applicable |

# Corporate Governance Statement 2016/17

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

The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during May, June and July 2015. The outcome of this review was reported to Trust Board in July 2015.

In summary, following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded that there were no 'material governance concerns'. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. In terms of the outcome, this reflected the developmental approach taken by Trust Board and the report very much reflected Trust Board's own assessment of the Trust's arrangements. The report identified a series of helpful and constructive areas for development around clear articulation of our strategic priorities and strengthening how these are communicated, clear monitoring and reporting against these, further development of the Board assurance framework, monitoring and assurance of the Trust's transformation programme, and strengthening and enhancing staff engagement. These formed the basis of an action plan with timescales, which Trust Board has taken forward. In the latest report to Trust Board in April 2016, the good progress made was acknowledged. Further work will be undertaken by the Executive Management Team to close the actions prior to presentation of a final report to Trust Board in September 2016. Internal audit will undertake a review of implementation as part of its audit work for corporate governance arrangements in 2016.

*Risks*

*Trust Board is unable to complete the actions agreed against the recommendations resulting in a less than significant assurance opinion from internal audit. Mitigated by further review, led by the Director of Corporate Development, with the Chief Executive and Director of Finance, and the Executive Management Team with presentation of the completed action plan to Trust Board (September 2016).*

*The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.*

The Trust was also subject to an inspection by the Care Quality Commission (CQC) in March 2016. The Trust received the report for factual accuracy checking early in June 2016 and a response has been sent to the CQC.

*Risk*

*The outcome of the inspection may not provide the rating expected. Mitigated by a communications and engagement plan in place and action plan to address areas for improvement.*

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment was presented to Trust Board in September 2015.
- The Trust undertakes an annual assessment of compliance against Monitor's Code of Governance and this is reported to Trust Board (June 2015).
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring checks in place.
- All elections made to the Members' Council are held in accordance with the election rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Electoral Reform Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence. Trust Board makes a quarterly self-certification as part of the Trust's quarterly return to NHS Improvement and annually receives a full assessment of compliance against the terms of its Licence. Should any risks emerge, Trust Board would be informed and action plans to address non-compliance would be put in place to mitigate risk and ensure ongoing compliance.

*Risk*

*The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and quarterly reporting to Trust Board as part of the Monitor reporting process.*

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place.

- NHS Improvement's governance risk rating represents its view of governance at the Trust. The Trust rated green in all four quarters of 2015/16 and made a declaration in its operational plan for 2016/17 that it would continue to do so during 2016/17.
- The Head of Internal Audit Opinion for 2015/16 provided significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in Monitor's Foundation Trust Annual Reporting Manual. The Statement for 2015/16 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's assurance framework and risk register have been assessed as appropriate as part of an internal audit of the Trust's risk management processes. As agreed by Trust Board, a review of both documents has been initiated for presentation in quarter 1 of 2016/17 to improve reporting to Trust Board. This review will incorporate work to assess and agree the Trust's 'risk appetite'.

*Risk*
*The Trust does not continue to report as 'green' for its governance risk rating. Mitigated by close scrutiny of NHS Improvement performance targets by the Executive Management Team quarterly reporting to Trust Board as part of the NHS Improvement reporting process.*

**2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time-to-time.**

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from Monitor, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.
*Risk*
*Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.*

**3. The Board is satisfied that the Trust implements:**
- **a) effective board and committee structures;**
- **b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees; and**
- **c) clear reporting lines and accountabilities throughout its organisation.**

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and Committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust has four risk-based Committees:

- Audit Committee;
- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee;
- Remuneration and Terms of Service Committee.

Committees are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. Agendas, which are risk-based, are compiled and agreed by the Chair of the Committee in conjunction with the Lead Director. Each Committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Director of Corporate Development in her role as Company Secretary, that papers are commissioned to meet the requirements of the Committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

Trust Board has also established three time-limited Forums, led by a Non-Executive Director, to scrutinise a particular area in more detail. These cover estates, information management and technology, and equality and diversity.

The membership of Committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The Committee structure is reviewed for appropriateness from time-to-time by the Chair.

Each Committee is required to prepare an annual report, which is presented to the Audit Committee. This provides assurance to Trust Board that each Committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. Further work will be undertaken during 2016 to develop a set of evaluation measures to support the annual reporting process in terms of the impact and added value Committees make.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge his accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by BDU, and to ensure the work of the EMT is aligned with that of Trust Board.

The sequencing of EMT meetings continues to provide a focus on delivery, providing an internal focus on performance and delivery of corporate objectives, and transformation and risk providing an external focus, and. These meetings are aligned with Trust Board processes to ensure Directors receive assurance regarding Trust operations. The weekly Operational Requirement Group, chaired by the Chief Executive, continues to meet weekly to ensure and facilitate effective operational delivery of the Trust's annual plan.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by the Quality Academy, which provides co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development. A review of Director portfolios will be undertaken during 2016, led by the Chief Executive.

*Risk*

*The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.*

**4. The Board is satisfied that the Trust effectively implements systems and/or processes:**

- **a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;**
- **b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;**
- **c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;**
- **d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licence holder's ability to continue as a going concern);**
- **e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making;**
- **f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence;**
- **g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where `appropriate, external assurance on such plans and their delivery; and**
- **h) to ensure compliance with all applicable legal requirements.**

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2015/16. There were no issues identified to report in the audit opinion.

*Risk*

*The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.*

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2016/17. The plan includes core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, corporate governance arrangements, which will focus on Care Quality Commission inspection and well-led review follow up, payroll, risk management and board assurance framework, and information governance toolkit. This is supported by a number of cyclical and risk reviews covering serious incidents, trio effectiveness and benefits realisation, clinical record keeping/data quality, delivering service change, workforce strategy, and support services value for money focussing on IT services. Internal audit will also undertake follow up reviews of limited assurance audits in 2015/16, including patients' property, job planning and medicines management.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives performance reports on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and performance targets. Other reports to Trust Board and its Committees provide 'soft' information that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. The Trust was subject to an inspection by the CQC in March 2016. An action plan will be developed in response to recommendations included in the inspection report. For 2016/17, the Trust's programme of visits to services will focus on areas 'requiring improvement' in the report. The Trust still has two compliance actions from a CQC inspection visit to Fieldhead in 2013. The submitted action plan addressing environmental improvements was fully completed by 31 May 2014. It is not known if the CQC will remove the compliance actions as a result of its inspection. Mental Health Act visits occur regularly and, following each visit, an action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports and the Trust's operational plan for 2016/17, supported by Audit opinion, the Trust will remain a going concern at all times. As part of its accounts audit for 2015/16, the Trust's external auditor was able to agree with management's view that the Trust could continue as a going concern for the next twelve months. The coming year presents a challenge to the Trust in meeting its operational and financial plans. Trust Board will review the Trust's position at its meeting in July 2016 in terms of the first three months of 'trading' and the outcome of the CQC inspection. Deloitte also undertook a review of the Trust's financial plan for 2016/17. Deloitte found that, for many schemes, it concurred with the Trust's assessment; however, where there was disagreement, Deloitte generally assessed a greater degree of delivery risk than that identified by the Trust. Deloitte raised 21 recommendations for management to consider.

*Risk*

*The Trust is unable to meet the requirements of its operational and financial plans for 2016/17. Mitigated by a review at month 3 (reporting to Trust Board in July 2016) to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.*

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

**5. The Board is satisfied that:**

**a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;**
**b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;**
**c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care;**
**d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;**
**e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and**
**f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**

Trust Board continues to use Monitor's Quality Governance Framework as a basis for providing assurance that the Trust has systems and processes in place to deliver quality services. Regular reviews against the Framework have taken place identifying a range of evidence to demonstrate compliance with the criteria. This evidence includes:

- policies developed, reviewed and in place;
- governance systems;

- the assurance framework and risk register presented to Trust Board quarterly;
- audits undertaken both internally and externally;
- the programme of unannounced visits; and
- reports submitted to Trust Board and its Committees, as well as the Members' Council.

The Trust's Quality Report for 2015/16 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual (2015/16) issued by Monitor and consistent with documents reviewed. In terms of the performance indicator testing of two mandatory indicators (access to crisis resolution home-based treatment and delayed transfers of care), a small number of minor errors or points for improvement were identified; however, the impact was not considered to be significant. For DToC, which was tested in 2014/15, this represents an improvement in performance. The review of the local indicator (care plans) has resulted in a number of recommendations, which will be taken forward by management.

The process introduced by the Director of Nursing to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2016/17. The Quality Impact Assessment, led by the Director of Nursing and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the EMT and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services. In 2016/17, assessment of the impact of substitutions or mitigating action are included in the process as well as cost pressures.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its Committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

Changes at Director level have enabled a stronger management structure to be developed for each BDU with the appointment of deputy directors providing operational leadership and management. This allows BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. This is supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

The Trust's approach to clinical quality improvement is supported by the Quality Academy approach, which is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The

Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board. Areas where Trust Board has set stretching targets and commissioned action plans to improve performance include sickness absence, data quality, estates, the Trust's approach to information management and technology, and equality and diversity. Board-level forums to provide more detailed assurance were established in the last three areas, led by a non-executive director.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service user experience is set out in its Involving People Strategy. Regular meetings are also held in community and ward settings to receive service user and carer feedback. The Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact and a service user insight framework has been introduced.

The Trust continues to be involved in development nationally of the Pathways and Packages approach to organising care and the implementation of this approach. This has formed the foundation of the Trust's approach to service line management and currency development. The Trust's approach is monitored through the Audit Committee in terms of process and financial performance, and the Clinical Governance and Clinical Safety Committee in relation to the impact on clinical services and assurance provided to Trust Board through Key Performance Indicators and specific reports.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing, Clinical Governance and Safety, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

*Risk*
*The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users/carers and staff, clear process in place for whistleblowing, processes in place for recruitment and selection of Trust Board members.*

## 6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. This process began in May 2016 with members of Trust Board undertaking a Strengths Deployment Inventory (SDI), a tool to understand and influence the motives that drive behaviours, providing insight to enable individuals to better understand how to influence people. This will also support work in terms of identifying gaps and enabling effective succession planning as well as evaluating Trust Board's effectiveness.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors and Governors. Trust Board undertakes ongoing Board development, using external expertise where required.

The Chief Executive is subject to formal review by the Chair twice-yearly. Executive Directors are subject to quarterly appraisals by the Chief Executive and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Remuneration and Terms of Service Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing, Clinical Governance and Safety, and the Medical Director.

The Trust also has a programme in place for all managers within the Trust at Bands 7 and above, Middleground, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level. The Talent Pool is now well-established to identify, nurture and develop talent within the organisation.

*Risk*
*The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.*

# Trust Board 28 June 2016
# Agenda item 8 – assurance from Trust Board Committees

## Audit Committee

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|---|---|
| **Date** | 23 May 2016 |
| **Presented by** | Laurence Campbell |
| **Key items to raise at Trust Board** | This meeting considered the Trust's annual report, accounts and Quality Report and is covered under agenda item 7.1. |

## Clinical Governance and Clinical Safety Committee

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|---|---|
| **Date** | 17 May and 14 June 2016 |
| **Presented by** | Julie Fox |
| **Key items to raise at Trust Board** | The meeting on 17 May 2016 considered the Trust's Quality Report and is covered under agenda item 7.1.<br><br><u>14 June 2016</u><br>➢ Child and adolescent mental health services.<br>➢ The Committee received a useful presentation on Duty of Candour.<br>➢ Safer staffing and the challenges presenting currently with pressures on services and recruitment and retention.<br>➢ Incident management annual report 2015/16, which is covered under agenda item 6.3(ii) on this agenda.<br>➢ Position in Barnsley in relation to the cost improvement programme. |

## Mental Health Act Committee

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|---|---|
| **Date** | 17 May 2016 |
| **Presented by** | Julie Fox |
| **Key items to raise at Trust Board** | ➢ Increased use of S49 (Court orders) and its impact on the Trust.<br>➢ The Committee received an excellent presentation on the impact of the transformation of learning disability services on use of the Mental Health and Mental Capacity Acts.<br>➢ Use of S136 suites and the impact of street triage services.<br>➢ Consent to treatment audit and concern of the Committee that not all wards completed the audit.<br>➢ Interoperability and access to the Trust's clinical information system and DATIX by local authority partners. |

## Remuneration and Terms of Service Committee

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|---|---|
| **Date** | 24 May 2016 |
| **Presented by** | Ian Black |
| **Key items to raise at Trust Board** | The Committee received an update on the management and administration review, and the Directors' performance related pay scheme. |

## Estates Forum

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| **Date** | 7 June 2016 |
| **Presented by** | Jonathan Jones |
| **Key items to raise at Trust Board** | ➢ Capital plan 2016/17.<br>➢ Development of community hubs in Wakefield and Pontefract.<br>➢ Development of non-secure estate on the Fieldhead site.<br>➢ Castleford, Normanton and District Hospital. |

## Equality and Inclusion Forum

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|---|---|
| **Date** | 21 June 2016 |
| **Presented by** | Ian Black |
| **Key items to raise at Trust Board** | ➢ Insight programme to improve the equality and diversity of Boards<br>➢ Mental health service users moving into employment, volunteering and training<br>➢ Commitment to invite for service user and carer involvement in the evaluation of the implementation of the Accessible Information Standard<br>➢ Equality workforce annual report 2015 and links to development of workforce strategy |

# Trust Board 28 June 2016
# Agenda item 8.7

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|---|---|
| **Title:** | **Membership of Trust Board Committees** |
| **Paper prepared by:** | Chair of the Trust |
| **Purpose:** | The purpose of this paper is to update Trust Board on Non-Executive Director membership of Committees following the Chair's annual reviews with Non-Executive Directors. |
| **Mission/values:** | Trust Board Committees are part of the Trust's governance arrangements, which support the Trust to achieve its mission and its objectives. |
| **Any background papers/ previously considered by:** | None. |
| **Executive summary:** | Following the appointment of three Non-Executive Directors in 2015, the Chair has undertaken a review of Committee membership as part of his annual reviews with Non-Executive Directors. Revised Committee membership is proposed as follows.<br>Audit Committee – membership remains as it is currently pending a further review later in 2016.<br>*Laurence Campbell (Chair), Chris Jones and Jonathan Jones*<br>Clinical Governance and Clinical Safety Committee – membership remains as it is currently; however, the Chair will review his membership later in the year with a view to ensuring strong Non-Executive Director links between Committees.<br>*Julie Fox (Chair), Ian Black and Charlotte Dyson*<br>Mental Health Act Committee – membership will remain as it is currently with a move to appoint Chris Jones as Chair from November 2016 or March 2017.<br>*Julie Fox (Chair), Chris Jones and Jonathan Jones*<br>Remuneration and Terms of Service Committee – membership will remain as it is currently with a move to appoint Rachel Court as Chair from October 2016.<br>*Ian Black (Chair), Rachel Court and Jonathan Jones*<br>Charitable Funds Committee – membership of this Committee will change from 1 July 2016 with the appointment of Charlotte Dyson as Chair and Ian Black and Laurence Campbell remaining as members.<br>There is no change to Executive Director membership of Committees at the current time. |
| **Recommendation:** | **Trust Board is asked to SUPPORT the changes proposed by the Chair.** |
| **Private session:** | Not applicable |

# Trust Board 28 June 2016
# Agenda item 9

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|---|---|
| **Title:** | **Use of Trust seal** |
| **Paper prepared by:** | Chief Executive |
| **Purpose:** | The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders. |
| **Mission/values:** | The paper ensures that the Trust meets its governance and regulatory requirements. |
| **Any background papers/ previously considered by:** | Quarterly reports to Trust Board |
| **Executive summary:** | The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive.<br>The seal has been used five times since the report to Trust Board in March 2016 in respect of the following.<br>- Agreement for lease with landlord's works (new build) relating to land at Drury Lane, Wakefield, between Quest (Wakefield) Limited and the Trust.<br>- Contract for sale of freehold land at Elmfield House, Halifax.<br>- Agreement for provision of 0-5 health visiting services between Barnsley Council and the Trust.<br>- Deed of variation for school nursing services between Barnsley Council and the Trust.<br>- Lease in relation to land and building at Drury Lane, Wakefield, between Quest (Wakefield) Limited and the Trust. |
| **Recommendation:** | **Trust Board is asked to NOTE use of the Trust's seal since the last report in March 2016.** |
| **Private session:** | Not applicable |