South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
Friday 22 July 2016
10:00 (with refreshments available from 9:30) and ending with lunch at 12:30
Legends Suite, Oakwell Stadium, Barnsley FC, Grove Street, Barnsley, S71 1ET

Item	Time	Subject Matter	Presented by		Action
1.	10:00	Welcome, introductions and apologies	Ian Black, Chair	**Verbal item**	To receive
2.		Declaration of Interests	Ian Black, Chair	**Paper**	To agree
3.		Minutes of the previous meeting held on 6 May 2016	Ian Black, Chair	**Paper**	To agree
4.	10:10	Chair's report and feedback from Trust Board Chief Executive's comments	Ian Black, Chair Rob Webster, Chief Executive	**Verbal item**	To receive
5.	10:20	Care Quality Commission – update on our inspection	Tim Breedon, Director of Nursing	**Discussion item**	To receive
6.	11:30	Update on Trust's financial position and implications for the Trust's operational plan	Mark Brooks, Director of Finance	**Presentation**	To receive
7.	11:40	Performance report Quarter 1 2016/17. *The full performance report for month 3 2016/17 will be tabled at the meeting. There will also be a presentation of the key issues.*	Mark Brooks, Director of Finance	**Presentation**	To receive
8.	11:50	Annual report, accounts and Quality Report 2015/16	Mark Brooks, Director of Finance/Tim Breedon, Director of Nursing Paul Hewitson, Deloitte	**Paper/ presentation**	To receive

Item	Time	Subject Matter	Presented by		Action
9.	12:10	Implementation of the upgrade to the Trust's clinical information system (RiO)	Mark Brooks, Director of Finance/Dawn Stephenson, Director of Corporate Development	**Paper**	To receive
10.	12:20	Customer services and serious incidents annual reports 2015/16	Dawn Stephenson, Director of Corporate Development/Tim Breedon, Director of Nursing	**Paper**	To receive
11.		Members' Council business items			
	12:25	11.1 Appointment of Lead Governor	Ian Black, Chair	**Paper**	To agree
12.	12:30	Closing remarks and date of next meeting	Ian Black, Chair	**Verbal item**	

Friday 4 November 2016

Morning meeting
Conference room 1, Textile Centre of Excellence, Textile House, Red Doles Lane, Huddersfield, HD2 1YF

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
22 July 2016

Agenda item:	**2**
Report Title:	Members' Council Declaration of Interests
Report By:	Dawn Stephenson on behalf of the Chair
Job Title:	Director of Corporate Development
Action:	To agree

EXECUTIVE SUMMARY

Purpose and format

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

Recommendation

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

Background

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

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

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

Process

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

Members' Council Declaration of Interests

Governor	***Description of interest***
CARRINGTON, Jessica Appointed, Wakefield Council	➢ Member, Featherstone and District Lions International Charity
CLAYDEN, Bob Publicly elected, Wakefield	➢ Chair, Portobello Community Craft and Camera Group ➢ Contracted for four sessions as a freelance artist by Next Generation Artzone (may be employed by groups funded or partially funded by the Trust)
CRAVEN, Jackie Publicly elected, Wakefield	➢ Board member, Young Lives ➢ Member, Alzheimer's' Society ➢ Volunteer, HealthWatch, Wakefield ➢ Member, Arthritis Care ➢ Parish Councillor, Crigglestone Parish Council ➢ Trustee, Crigglestone Village Institute ➢ Trustee, Worrills Almshouses ➢ Trustee, Hall Green Community Centre ➢ Trustee, 45 Durkar Scouts
CROSSLEY, Andrew Publicly elected, Barnsley	➢ Director, Pathway Sales Limited ➢ Part owner (and shareholder non-controlling), Liaison Financial Services ➢ Consultancy services via Pathway Sales Limited for Liaison Financial Services ➢ Volunteer, Samaritans, Barnsley ➢ Volunteer, Victim Support, Wakefield ➢ Volunteer, HealthWatch, Wakefield
ENRIGHT, Trudi Publicly elected, Calderdale	➢ Bank nurse, Wakefield Hospice ➢ Our Minds Ltd. – dormant company and not practicing currently
HAWORTH, John Staff elected, non-clinical support staff	No interests declared
IRVING, Carol Publicly elected, Kirklees	No interests declared
KENDAL, Sarah Appointed, University of Huddersfield	➢ Member, Board of Trustees, 42nd Street (young people's mental health charity, Manchester) ➢ Head of Division, Mental Health and Learning Disability, and Occupational Therapy, University of Huddersfield, which has a close relationship with the Trust
MASON, Ruth Appointed, Calderdale and Huddersfield NHS Foundation Trust	➢ Member, Board of Directors, 'Mind the Gap' theatre company, Bradford, which employs actors with a learning disability
WOODHEAD, David Publicly elected, Kirklees	No interests declared

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Members' Council meeting held on 6 May 2016

Present:	Marios Adamou	Staff – Medicine and pharmacy
	Ian Black	Chair of the Trust
	Garry Brownbridge	Staff – Psychological Therapies
	Bob Clayden	Public – Wakefield
	Jackie Craven	Public – Wakefield
	Andrew Crossley	Public – Barnsley
	Adrian Deakin	Staff – Nursing
	Michael Fenton	Public – Kirklees
	Claire Girvan	Staff – Allied Health Professionals
	Stefanie Hampson	Appointed – Staff side organisations
	Nasim Hasnie	Public – Kirklees
	John Haworth	Staff – Non-clinical support
	Andrew Hill	Public – Barnsley
	Carol Irving	Public – Kirklees
	Ruth Mason	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Bob Mortimer	Public – Kirklees
	Daniel Redmond	Public – Calderdale
	Jeremy Smith	Public – Kirklees
	Hazel Walker	Public – Wakefield
	Gemma Wilson	Staff – Nursing support
In attendance:	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Laurence Campbell	Non-Executive Director
	Jon Cooke	Interim Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	James Drury	Acting Director, Strategic Planning
	Charlotte Dyson	Non-Executive Director
	Alex Farrell	Interim Chief Executive
	Julie Fox	Deputy Chair
	Carol Harris	Director of Forensic and Specialist Services
	Kate Henry	Director of Marketing, Engagement and Commercial Devel.
	Chris Jones	Non-Executive Director
	Diane Smith	Director of Health Intelligence and Innovation
	Dawn Stephenson	Director of Corporate Development
Apologies:	Shaun Adam	Public – Barnsley
	Stephen Baines	Appointed – Calderdale Council
	Michelle Collins	Appointed – Wakefield Council
	Emma Dures	Appointed – Barnsley Council
	Trudi Enright	Public – Calderdale
	Chris Hollins	Public – Wakefield
	Sarah Kendal	Appointed – University of Huddersfield
	Jules Preston	Appointed – Mid Yorkshire Hospitals NHS Trust
	Phil Shire	Public – Calderdale
	Peter Walker	Public – Wakefield
	David Woodhead	Public - Kirklees

MC/16/12 Chair's appraisal (agenda item 1)

Led by Julie Fox, Deputy Chair, Governors participated in the Chair's appraisal. A report on the outcome will come to the meeting in July 2016.

MC/16/13 Welcome, introduction and apologies (agenda item 2)

Ian Black, Chair of the Trust, welcomed everyone to the meeting, in particular new members:

Shaun Adam, public – Barnsley
Bob Clayden, public – Wakefield
Trudi Enright, public – Calderdale
Stefanie Hampson, appointed – staff side
Carol Irving, public – Kirklees
Sarah Kendal, appointed – University of Huddersfield
Phil Shire, public – Calderdale
Jeremy Smith, public – Kirklees
Gemma Wilson, staff – nursing support

He also formally recorded the retirement of Michael Smith and Tony Wilkinson, publicly elected governors in Calderdale and the current and previous Lead Governors, following the recent election process. On behalf of the Members' Council, Bob Mortimer thanked both for their significant contribution and support both for the Trust and for the Members' Council.

MC/16/14 Declaration of interests (agenda item 3)

The Members' Council NOTED the individual declarations from newly appointed or elected governors and CONFIRMED the changes to the Register of Interests.

MC/16/15 Minutes of the previous meeting held on 12 February 2016 (agenda item 4.1) and notes from the joint meeting with Trust Board held on 12 February 2016 (agenda item 4.2)

The Members' Council APPROVED the minutes from the meeting held on 12 February 2016 and NOTED the notes from the joint meeting with Trust Board on the same day.
There were no matters arising.

MC/16/16 Chair's report and feedback from Trust Board/Chief Executive's comments (agenda item 5)

Chair's report

Ian Black began his remarks by commenting on one of his objectives for the year – "to get out more". In the spirit of meeting this objective, he provided feedback from the recent NHS Providers Board meeting. The financial position nationally is getting tighter and tighter as, indeed, it is at this Trust. This Trust's strong position is by no means universal across the NHS and it will be a difficult year to deliver against plans. Bob Mortimer asked if the Trust underspends whether it would receive less funding in the following year. The Chair responded that Trust Board set a budget and will deliver against it; however, Trust Board is not yet entirely confident of achieving the financial plan for 2016/17. In terms of taking money from the Trust, Trust Board is clear on its capital programme and use of the Trust's cash reserves to fund it; however, it will remain a pressure on the Trust throughout the year and will also be covered at future meetings.

The Chair went on to comment on the Junior Doctors' industrial action and the assurance provided to the Department of Health that the Trust has robust and effective plans in place to address any pressures as a result of the action. The Trust has relatively few junior doctors and its services do not have significant reliance on junior doctors in contrast with many trusts in the acute sector. Plans are in place 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. He also commented that it is positive that both sides have plans to continue talks.

Barnsley 0-19 services were tendered by Barnsley Council with a reduction in funding. Trust Board took the decision, following advice from the Medical Director and Director of Nursing

as a result of detailed clinical and managerial analysis of risk, that it could not be assured that the proposed service model could be delivered safely within the financial envelope available. The decision was not an easy one to take but was absolutely the right one for the Trust. Barnsley Council will take the services in-house and the Trust is currently in discussions about transition and handover. Adrian Deakin asked if there was any pressure from commissioners for the Trust to continue to deliver the services. Ian Black responded that it was a decision for the Trust alone to make and it is now working with the Council to transfer the services and staff safely. Claire Girvan asked if the Trust knows when services will come up for tender. Alex Farrell responded that there is a stocktake by Trust Board in April each year supported by a quarterly update. She would be happy to share this with the Members' Council. Jackie Craven asked whether the decision in Barnsley has impacted on other parts of the Trust. Ian Black responded that Barnsley is the only district where the Trust provides these services; however, many other services across the Trust will be subject to tender. He confirmed that the Trust's contract has been extended to 30 June 2016 to allow for the transfer of services. Andrew Hill asked who would monitor the quality of services in future. Alex Farrell responded that the Council has commissioned an external adviser to support the transition, the Care Quality Commission will inspect services and commissioners will also assess the impact on other services, such as primary care. The Trust has a responsibility to ensure the services are transferred safely. This will no doubt be the subject of ongoing discussion between the Trust, commissioners and the Council.

Ian Black went on to report that the Trust has won two awards recently – one for the development of Laura Mitchell House and the other for nomination of the Calderdale and Kirklees Police liaison service from the Health Service Journal.

Ian Black welcomed Carol Harris, Director of Forensic and Specialist Services, and Mike Doyle, Deputy Director of Nursing. He also bid farewell to Alex Farrell as this was her last meeting. In planning, budgeting and delivery, the Trust has achieved what it said it would under her stewardship. From a staff point of view, Marios Adamou commended the security and safety the finance team has provided for the delivery of care under Alex Farrell's leadership. Ian Black also thanked Jon Cooke for his contribution and support during his time as interim Director of Finance, which will end at the beginning of June 2016.

<u>Chief Executive remarks</u>
Alex Farrell began her comments by thanking people for their kind words and wished everyone on the Members' Council well for the future. She raised a number of matters.

- The Trust has entered a transition phase for 0-19 services in Barnsley with the local authority and commissioners. Imperative is the safe delivery of services and that staff are protected.
- The Trust's accounts and quality accounts for 2015/16 are currently with the Trust's auditors.
- All contracts with commissioners have been signed and the Trust is not in arbitration with any contractor. The Trust has secured inward investment for early intervention in psychosis, child and adolescent mental health services (CAMHS) and dementia services.
- The Trust has embarked on a new service in partnership with Leeds Community Healthcare NHS Trust to provide CAMHS to Wetherby Young Offenders' Institution and Adel Beck Secure Children's Home. This is an excellent example of the Trust working in partnership with other organisations.
- She then provided an update on the four Vanguards the Trust is involved in and the development of Sustainability and Transformation Plans (STPs) across South and West Yorkshire. STPs aim to bring all health and social care providers together to develop a system-based approach to improve health outcomes. In South Yorkshire, the STP is chaired by Sir Andrew Cash, Chief Executive of Sheffield Teaching Hospitals NHS

Foundation Trust, and, in West Yorkshire, it is chaired by this Trust's Chief Executive designate, Rob Webster. Each district will have its own plan with cross-cutting themes and mental health is a priority in both. Plans are due to be submitted by 30 June 2016. An outline of the content will be presented to Trust Board in June 2016 and the Members' Council in July 2016.

- Bob Mortimer asked what influence the Trust has on local authorities with regard to the pathway to recovery. Alex Farrell responded that this is monitored through delayed transfers of care, which highlights instances where an individual is ready to move on but no place is available. Although there are some within the Trust, it is not at a level which would cause significant problems for the Trust.

MC/16/17 Annual plan and budget 2016/17 (agenda item 6)

James Drury took the Members' Council through the content of the operational plan. Adrian Deakin asked if the national promise of investment in CAMHS had materialised and where it was going. It was confirmed that plans at a national level were set out in 'Future in Mind' and that the Trust has received direct investment to provide an eating disorder service, investment to support liaison with primary care in schools and investment in a single point of access in one area. The Trust will also benefit from additional investment in other services within its area. The Trust will also take advantage of the inward investment to develop its attention deficit hyperactivity disorder (ADHD) service.

Daniel Redmond asked if there had been any progress with the Priory development. Alex Farrell responded that negotiations have re-opened on the Tier 4 CAMHS proposal but no timescales have been confirmed.

Andrew Hill commented on the proposed move of rehabilitation services at Mount Vernon to the general hospital in Barnsley. Alex Farrell responded that this was part of a wider review of intermediate care in Barnsley by the clinical commissioning group (CCG) and the outcome will be known shortly. Mount Vernon is not necessarily fit for purpose in the longer-term and will be part of the review.

Jon Cooke outlined the financial aspects of the Trust's plan and provided assurance to the Members' Council that robust contingency and handover processes are in place during changes at senior level. He went on to comment that NHS Improvement set control totals for provider Trusts in England in order to bring the NHS back into balance. The requirement for this Trust is £1.2 million; however, it is making a £750,000 investment in safer staffing, which means that the plan submission recognises a £500,000 surplus budget. There are also £10 million efficiencies, which will be challenging, and the focus will be on reduction in management and administration costs rather than front-line services.

Adrian Deakin commented that taking £5.1 million out of agency spend is a big sum year-on-year. Ian Black responded that this is a big number but the Trust must seek to reduce its spend in this area. John Haworth commented that doctor vacancies contribute to agency spend and he was aware recruitment is ongoing. He asked how spend on covering vacancies compared to the use of agency staff to cover short and/or long-term absence. It was agreed the Trust would provide the figures.

Marios Adamou asked if there was provision for investment in information management and technology (IM&T). Jon Cooke responded that planned capital investment of £1.1 million is planned in 2016/17 and there will also be a focus on implementing a digital strategy across the Trust. Marios Adamou asked if this would cover support for enhanced medical technology. Ian Black responded that this should also be an area for development and it may be that pressure on spend means investment in IM&T has to increase.

Andrew Crossley asked what would happen if the Trust did not deliver its cost improvement programme. Ian Black responded that the Trust would not deliver a surplus and, at the current time, he was not yet entirely confident that the cost savings would be fully achieved. Once the outcome of the CQC inspection is known, Trust Board can review whether the investment in safer staffing is sufficient. This will also provide information on two/three months of trading needed before Trust Board can review and assess the position. He is nervous; however, Trust Board has taken the right decision to approve the operational plan and budget. He undertook to provide an update to July's meeting.

Nasim Hasnie asked how far digitalisation has been embraced in comparison with other Trusts. Ian Black responded that he did not think that it had been far enough. Alex Farrell added that the Trust had been asked to complete a survey on its position along with other providers in the area. Some areas were not as advanced; however, in some areas, the Trust is performing well. The outcome also offers good benchmarking for the future.

In response to a question from Daniel Redmond, Ian Black confirmed that the Trust is responsible for developing its own IM&T Strategy and for developing a response to its own needs. Part of this strategy is to enhance and support the interface with other organisations.

John Haworth commented that the plan assumes that Commissioning for Quality and Innovation targets (CQUINs) will be met but last year the Trust did not achieve the full monies available. He asked what plans were in place to address any risk this year. Jon Cooke responded that contract negotiations have ensured that the Trust jointly agrees CQUINs with commissioners that act as an incentive and stretch to improve the quality of services delivered. The risk has not been eliminated but achievement is more likely. Alex Farrell added that there were two areas where the Trust under-achieved in 2015/16 in relation to physical and mental health, and recording of mental health clusters/currency. Performance is much improved but the Trust was unable to meet its targets. Negotiations with commissioners for 2016/17 means the Trust is in a much better position to be able to meet its targets.

Ian Black committed to providing a further update in July 2016. The priority for Trust Board is safety and the most effective delivery of services. The budget/money is just one aspect of this.

MC/16/18 Transformation update (agenda item 7)

Ian Black invited questions from the Members' Council. John Haworth asked for an explanation of the acute and community mental health stepped model. Alex Farrell responded that it provides a tiered explanation of the Trust's service response to the needs of individuals presenting in services. In response to comments from Jackie Craven, Alex Farrell commented that all recovery colleges have developed a prospectus to describe what they offer and confirmed Trust support for this.

MC/16/19 Implementation of the upgrade to the Trust's clinical information system (RiO) (agenda item 8)

Jon Cooke updated the Members' Council on the current position. The perspective from staff governors was that the situation was getting better and support has been available; however, the issues have caused frustration and have reduced confidence in the system.

Dawn Stephenson confirmed that she has commissioned an independent review from Deloitte. Terms of reference and the scope have been agreed and the investigation has begun. The draft report with clear recommendations will be received in the week beginning

23 May 2016 for presentation to the Board Information Management and Technology Forum on 13 June 2016 prior to Trust Board on 28 June 2016.

Stefanie Hampson asked if the Trust could be confident that, if this was to happen again, staff would still be able to function. Alex Farrell responded that there will be a re-launch of this version of RiO with additional training for staff to see the benefits of the upgrade. Contingency plans are in place for teams, which will be reviewed when issues are resolved. John Haworth expressed a concern regarding other packages, such as e-learning, which also have problems and frustrations for staff. Alex Farrell responded that the current situation also provides an opportunity to review how the Trust manages external IT packages. John Haworth also asked if the investigation would cover the Trust's IT provider, Daisy. Alex Farrell responded that the independent investigation will cover all aspects of the upgrade, including the Trust, its preparation, the support provided and the IT provider.

Ian Black commented that the fundamental driver for new and existing systems is that data held on individuals is completely confidential. Alex Farrell confirmed that the Trust is compliant will access requirements for service user information and processes are in place to request access. Ian Black added that the Trust makes extensive use of social media, both internally and externally.

Jeremy Smith asked why the Trust had not simply gone back to V6 of the RiO system. Alex Farrell responded that this was considered and a formal review of the options undertaken. The technical issues involved would have meant there could be no guarantee that data input since the upgrade would be transferred.

MC/16/20 Performance report Quarter 4 2015/16 (agenda item 9)

The performance report was noted. Ian Black commented that the Trust is looking to change the format and presentation of the report and work has begun to do this.

MC/16/21 Care Quality Commission – update on our inspection (agenda item 10)

Mike Doyle presented an update on the inspection undertaken by the CQC. Ian Black explained that the Trust was aiming for 'good'. For him, that staff were found to be caring without exception was the main feature of the informal feedback from the CQC. The whole organisation was involved in the inspection and inspectors were treated in the proper manner; however, in the end, it is the job staff do every day that matters. Mike Doyle added that there will be a quality summit involving the Trust, its stakeholders, users of services and people consulted as part of the inspection. This will take place over the summer. He also advised that there will be fourteen reports and ratings to reflect core services with one overarching report and rating.

Bob Mortimer commented that governors had had a constructive and supportive meeting with the CQC. Nasim Hasnie confirmed that it had been a good experience and governors were able to demonstrate the support they provided to the Trust. John Haworth commented that the Trust's co-ordination and administration of the inspection visit functioned very well organisationally and was exemplary. Adrian Deakin commented that staff had not behaved any differently because the inspectors were on site; however, there were some difficulties with the involvement of carers and relatives and their willingness to speak to the CQC.

Ian Black commented that he will ensure governors are informed of the outcome as soon as is practicable.

MC/16/22 Members' Council business items (agenda item 11)

Members' Council elections (agenda item 11.1)
The report from Dawn Stephenson was noted.

Appointment of Lead Governor (agenda item 11.2)
A paper was circulated outlining the role and process for the appointment. Governors were asked to discuss any interest with Ian Black before making an application. Ian Black also advised that he was seeking governors to join the Members' Council Co-ordination Group, the Nominations Committee and the Members' Council Quality Group. New governors were welcome to join the groups as their input is equally as valuable as that of more experienced governors. He confirmed that Andrew Hill has been invited to Chair the next meeting of the Co-ordination Group.

The Members' Council supported the proposed process for formal approval of an appointment at July's meeting.

Review of Audit Committee terms of reference (agenda item 11.3)
Dawn Stephenson introduced this item. Laurence Campbell, Chair of the Audit Committee, commented that this was an important part of Trust Board assurance regarding the systems and controls in place and that Committees are fulfilling their terms of reference.

The Members' Council noted the Audit Committee terms of reference.

Chair's appraisal – next steps (agenda item 11.4)
Julie Fox provided a follow up to the interactive process earlier in the meeting. Governors that could not attend this session will be given an opportunity to complete the questionnaire electronically. Trust Board has also completed a questionnaire and Ian Black a self-assessment. The outcome of the three strands will be pulled together for Julie Fox to feedback to the Chair to identify good practice and areas for development. Any further comments from governors were welcomed. The outcome will be presented to the Members' Council in July 2016.

MC/16/23 Date of next meeting (agenda item 12)

The next meeting will be held in the morning of Friday 22 July 2016 in the Legends Suite, Oakwell Stadium, Barnsley FC, Grove Street, Barnsley, S71 1ET.

In his closing remarks, Ian Black observed that one of the best ways for governors to hold Non-Executive Directors to account is through attendance at Trust Board meetings and he encouraged all governors to do so. He also advised that he is looking to change the date of the October meeting and further information will be sent out in due course.

On behalf of the Members' Council, Andrew Hill made a presentation to Alex Farrell who thanked governors and commented that she had enjoyed working with everyone and wished governors every success in the future.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

MEMBERS' COUNCIL 6 MAY 2016 – ACTION POINTS

Minute ref	Action	Lead	Timescale	Progress
MC/16/12 MC/16/22	Present outcome of Chair's appraisal	JF	July 2016	Agenda item July 2016
MC/16/16	Provide outline of content of Sustainability and Transformation Plans submissions in South and West Yorkshire	Lead to be agreed	July 2016	Briefing to be provided for Members' Council
MC/16/17	Provide figures on use of agency staff to cover vacancies and to cover short/long-term absence	AGD/MB	Update to July 2016	Include as part of performance reporting
	Provide further update on the Trust's financial position and implications for Trust's operational plan	MB/JD	July 2016	Agenda item July 2016
MC/16/19	Provide update on independent review of implementation of RiO upgrade and action Trust will take as a result	DS	July 2016	Agenda item July 2016
MC/16/20	Provide update on outcome of CQC inspection	TB	July 2016	Agenda item July 2016
MC/16/22	Make a proposal regarding the appointment of Lead Governor	IB	July 2016	Agenda item July 2016
MC/16/23	Confirm date of Autumn Members' Council meeting	IB		Done 8 June 2016

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
22 July 2016

Agenda item:	**5**
Report Title:	Care Quality Commission inspection outcome
Report By:	Tim Breedon
Job Title:	Director of Nursing and Professions, Clinical Governance and Safety
Action:	Discussion item

EXECUTIVE SUMMARY

Purpose and format

The purpose of this item is to provide the Members' Council with an opportunity to discuss the outcome of the Trust's Care Quality Commission inspection and to identify where it can contribute to ongoing improvement activity.

Recommendation

This item forms the discussion item for today's meeting (see below).

Background

The Trust was inspected as part of the Care Quality Commission's (CQC's) routine comprehensive inspection process in the week commencing 7 March 2016. The scope of the inspection was vast looking at services from across the whole Trust and viewing information from all corporate services.

Draft reports for fourteen core services and one Trust-wide quality report were received by the Trust on 20 May 2016. The factual accuracy check was finalised on 10 June 2016 and the final reports were issued to the Trust on 20 June 2016. These were published on the CQC website on 24 June 2016. The reports are available on the Trust's website at the following link Care Quality Commission inspection reports.

Across these fourteen 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.

The Trust received 22 regulatory breaches across seven regulations. These are areas where the Trust is seen to be not adhering with the Health and Social Care Act and require immediate attention. The Trust is required to inform the CQC of the actions it is taking to address the breaches and will be monitored on these areas through CQC processes.

An action plan has been developed (attached) which addresses the regulatory breaches and 'must do' actions. This was presented to the Executive Management Team (EMT) on 7 July 2016 and Trust Board on 19 July 2016.

The plan describes the actions to be taken and indicates the lead allocated for each area. In addition to this plan, a more detailed plan has been developed with individuals assigned to specific actions and milestones agreed. The more detailed action plans will be performance managed through the relevant BDU or quality academy department and report into EMT on a monthly basis. The Clinical Governance and Clinical Safety Committee will monitor progress and report to Trust Board.

A Quality Summit was held on 14 July 2016 and the Trust was given an opportunity to respond to the concerns raised by the CQC with time allocated for a discussion on the proposed actions we plan to take to meet the regulatory breaches. A verbal update on the Summit will be given at the meeting.

A copy of the presentation provided at the Quality Summit is enclosed for information and the Chief Executive and Director of Nursing will take the Members' Council through the presentation on 22 July 2016.

Discussion item

The outcome of the CQC inspection will form the discussion item for the meeting on 22 July 2016.

The Chief Executive and Director of Nursing will take the Members' Council through the presentation made at the Quality Summit as an introduction to the item. This will also provide governors with an opportunity to ask any general questions.

This will be followed by group discussions. Each group will consider the following.

1. Governors' first thoughts on the findings and the Trust's response.
2. Identify two/three areas for further discussion and, specifically, where governors can have input and offer support to the Trust.
3. Identify which areas the Members' Council Quality Group should be looking at on behalf of the Members' Council and what should come back to the Members' Council on a regular basis.
4. In relation to implementation of the action plan and taking forward improvement activity, identify what questions governors want to ask/challenge Non-Executive Directors (as part of role to hold Non-Executive Directors to account) and what questions governors would want Non-Executive Directors to be asking of the Executive Management Team at Trust Board.

Draft v0.2

South West Yorkshire Partnership NHS
NHS Foundation Trust

CQC inspection quality summit

14 July 2016

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Ian Black - chair

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We must put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent in our dealings, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our approach

- We welcomed the inspection and the independent view
- It's an opportunity to continue improving our services for local people
- We've communicated widely about it, including discussions at our public Board meetings
- Our action plans are being co-produced with our partners
- Our Members' Council will help shape our action plans

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Rob Webster - chief executive

With **all of us** in mind.

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Our inspection

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

They spoke to people who use our services, their carers and the general public, our Members' Council and partner organisations

They received 676 comments directly

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

With **all of us** in mind.

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 our 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.

Areas that require improvement

Areas that require improvement include:

- Access issues in CAMHS and psychological therapies
- Elements of staffing
- Elements of internal governance
- One of our clinical information systems (RiO), following recent upgrade

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

South West Yorkshire Partnership NHS
NHS Foundation Trust

Tim Breedon - director of nursing and professions, clinical governance and safety

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Working together to support improvement

Key areas for action, developed collaboratively:

- Safer staffing – keeping and recruiting new staff
- Clinical supervision recording and reporting
- CAMHS access to treatment
- Mandatory training - ILS / MHA & MCA all now mandated and will be reported to our Board

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Working together to support improvement cont.

- Review of our internal inspection programme - aligned to CQC based risk model
- Improving the integration of physical and mental health
- Improving clinical information - clinical record keeping, data quality, care planning, risk assessments

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Next steps

- Displaying our ratings by tomorrow
- Members' Council on 22 July
- Action plan to be approved and monitored by our Board
- Submitting action plan to CQC by 9 August

With **all of us** in mind.

Next steps cont.

- Continuing staff engagement around quality improvement
- Keeping doing the ‘Good’ and ‘Outstanding’ things
- Improving things that are in need of improvement
- Embracing the learning in line with our values

With **all of us** in mind.

SWYPFT CQC Visit - Requirement Notice Action Plan

Final Version Dated – 8.7.2016

Ref	Issue identified	Action	Lead	Completion date
OVERALL REPORT				
TRN1	Three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014. This is a breach of regulation 5 (3) (a)	The three new non-executive directors have had their Disclosure and Barring Service Checks completed and have been issued with their standard certificates, copies of which are held by Human Resources.	Director of Corporate Development	Completed
TRN2	Mental Health Act and Mental Capacity Act training was not mandatory for any staff and was not monitored for effectiveness by senior management of the trust. This is a breach of regulation 18 (2)(a)	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016. 4. We have undertaken a review of the e-learning programme for level 1 MCA training. During June 2016 we received confirmation from SCIE Head of Digital to confirm that we can adapt the SCIE's e-learning programme. 5. We are developing training plans for MCA using core training guidance that was issued by NHS England. Training flyers are available and training information will be advertised in weekly bulletins during July and August 2016. 6. E-learning packages are to be developed for the Mental Health Act. This training will interface with the MCA training. Training plans and	Assistant Director of Legal Services	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
		dates have been put in plan. 7. There is an internal Trust Training plan for MHA/MCA for all registered staff working within mental health services. Training dates are available and are advertised on the trust intranet. 8. Reporting compliance with the MHA/MCA training will be sent to the Trust Board and senior managers. Reporting compliance via performance will be sent to individual staff and managers on a monthly basis. These reporting structures will feed into the MHA Committee. 9. A new MHA/MCA sub-group has been established and will report into the MHA Committee. 10. The MHA/MCA training plan will be reviewed in October 2016. 11. We will be looking at the continued implementation of the training plan including refresher dates. 12. There are plans to establish practical scenario based refresher training for all registered and support staff (clinical) by October 2016. 13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.		
TRN3	The 2015 MHA code of practice had not been implemented across all services of the trust. This is a breach of regulation 17(2)(a)	As a trust wide approach we are going to take the following actions: 1. We are commissioning a MHA/MCA clinical reference group. 2. All areas have removed outdated MHA Code of Practice information. 3. We have sent reminders to staff that the MHA Code of Practice 2015 is available on the intranet. Information will also be provided in weekly bulletins during July and August 2016. BDU Deputy Directors will include the MHA Code of Practice as an agenda item within their respective BDU meetings. 4. MHA Code of Practice training is now mandatory and training is in place. New doctors will attend induction training which now incorporates a dedicated MHA session. 5. In April 2016 we developed a MHA Code of Practice policy action plan that was sent to all identified leads for review. 6. BDU's were asked to review all operational procedures to ensure	Director of Nursing Clinical Governance & Safety	July 2016 and then ongoing until 31st March 2017

Ref	Issue identified	Action	Lead	Completion date
		compliance with the MHA Code of Practice 2015. From this BDU's provided a list of their local procedures and assurances about their compliance with the code. 7. We are also planning a baseline audit of awareness of the current MHA Code of Practice. These audits will be carried out every 3-6 months. There will be an overall overview in 12 months' time and this will be aligned to the training plan.		
TRN4	Care records were both electronic and paper based and staff did not have access to contemporary, accurate and comprehensive patient's records. This is a breach of Regulation 17(2)(c)	The Trust has an improving clinical information working group and action plan. 'Multiple records' as described above, is one of the areas that the Trust has identified for action. The aim is to ensure our clinical record keeping system RIO is the one place for storage of all clinical records. Actions 1. Agree a policy standard and procedure around the use of RIO as the single storage point for all clinical information and records 2. Communicate the policy and procedure to eliminate risk caused by this practice	Director of Nursing, Clinical Governance & Safety	31st December 2016
Acute wards for adults of working age and psychiatric intensive care units				
AIRN1	Patients on ward 18, Priestley Unit, Dewsbury did not have risk assessments that had been fully completed or completed within trust policies and procedures. Staff did not have clear lines of sight on Trinity 2, Fieldhead Hospital and Ashdale and Elmdale wards at The Dales. Not all ligature risks had been identified on Beamshaw and Clarke ward at Kendray	**Wakefield (Trinity 2 and Fieldhead Hospital)** Lines of sight • We are carrying out an environmental risk assessment to look at where additional mirrors are needed to help line of sight. • Once improvements have been identified, we will liaise with the Estates department to install the mirrors in the areas identified. **Kirklees (ward 18)** Risk Assessments • We have emphasisied the need for fully documented risk	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
	Hospital. This is a breach of Regulation 12 (2)(a)(b)	assessment information within the trust policies and procedures with all qualified practitioners through targeted communication i.e. directly by e-mail and within staff meetings. • procedure is to be completed to determine if any latent issues exists or if the procedure can be improved in terms of clearly informing staff of potential and actual environmental risks. • A review of the content of the current assessment tool will be completed with the Health and Safety Department to determine if the assessment tool could be improved to aid clarity of use and clarity of interpretation • [Alongside other actions we will review the *Guidance notes: Environmental suicide and ligature point risk assessment tool* to ensure that it is fully compatible with the assessment tool and provides appropriate and up to date evidence based guidance. • On completion of the review re: assessment tool and guidance notes complete an environmental ligature risk assessment of Beamshaw and Clark Wards. • On completion of the review we will complete a risk management plan to manage or mitigate any ligature points identified. • Disseminate ligature point assessment and risk management plan to all ward staff – consideration should be given to maintaining an attendance list or log for all staff receiving a safety briefing re environmental ligature point risk assessment. • Ensure that ward 18 have updated risk assessments completed within trust policies and procedures which informs the current care plan. • Communication with all qualified practitioners (e-mail & staff meeting) • Implement risk assessment and care plan standards. • A BDU inpatient discharge planning group is being formed to learn from SI incidents to improve discharge planning which includes updating risk assessments, working in a whole systems way. • The Community and Acute Practice Governance Coaches are setting up a small working group to review how the whole system		

Ref	Issue identified	Action	Lead	Completion date
		achieves best practice standards for improving risk assessments, especially at the discharge planning stage. **Calderdale (Ashdale and Elmdale)** Lines of sight • A review is being undertaken with our Estates department to fit mirrors to improve lines of sight. • Fitting of appropriate mirrors **Barnsley (Beamshaw and Clark wards)** Ligature risks • We will be undertaking a review of the environmental ligature risk assessment and management process and post review complete an environmental risk assessment for Beamshaw and Clark wards. • Complete a review of the risk assessment tool [this is required as obviously the CQC misunderstood the purpose of the risk assessment tool and other individuals may also suffer from this misapprehension: the assessment tool is to assist in the identification of environmental risks within the premises as opposed to individual patient risk]. Therefore clarity of use and clarity of interpretation must be ensured: • To achieve this, a process mapping exercise of the assessment procedure is to be completed to determine if any latent issues exists or if the procedure can be improved in terms of clearly informing staff of potential and actual environmental risks . • A review of the content of the current assessment tool will be completed with the Health and Safety Department to determine if the assessment tool could be improved to aid clarity of use and clarity of interpretation • [Alongside other actions we will review the *Guidance notes: Environmental suicide and ligature point risk assessment tool* to ensure that it is fully compatible with the assessment tool and provides appropriate and up to date evidence based guidance.		

Ref	Issue identified	Action	Lead	Completion date
		• On completion of the review re: assessment tool and guidance notes, complete an environmental ligature risk assessment of Beamshaw and Clark Wards. • On completion of the review we will complete a risk management plan to manage or mitigate any ligature points identified. • Disseminate ligature point assessment and risk management plan to all ward staff – consideration should be given to maintaining an attendance list or log for all staff receiving a safety briefing re :environmental ligature point risk assessment.		
AIRN2	High dose medication was not routinely monitored across all wards. There were no completed monitoring forms and no information in patient records. This is a breach of Regulation 12 (2)(g)	**Wakefield** • A new form for monitoring for High dose Antipsychotics as suggested by Royal College is to be used in collaboration with pharmacy link professional. • We will be linking this work alongside the physical health monitoring pilot for monitoring purposes.. **Kirklees** • We will be working closely with the Pharmacy team to ensure the medicines code is correctly practiced. This will include reinforcing good practices with staff from inpatient teams (Medics & Registered Nurses) and how we monitor this. • The Clinical Lead (Dr Mathen) has been in communication with all consultants and ward managers about high dose monitoring. Dr Mathen has also provided a trust form for staff to record how high dosages of medication are being monitored. **Barnsley** • We will develop local guidelines on the use and monitoring of High Dose Antipsychotics. • The BDU's Trio, local lead pharmacist, ward mangers and Band 6 staff will form a working group to develop a guidance protocol on	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		the use of and monitoring of High Dose Antipsychotics. Issues or areas to be covered in the guidance will include such aspects as: - rationale for use of high dose and the recording of the same - use of more than one antipsychotic giving an aggregated high dose - assessment of physical risk e.g. cardiac, hepatic ,renal - assessment of potential drug interactions - monitoring arrangements in particular lipids and glucose - monitoring of side effects and side effect management - a description of nursing responsibilities - description of the doctors responsibilities - a description of the pharmacists responsibilities - review arrangements - development of a monitoring form [based on the requirements of the protocol - implementation of the High Dose guidelines		
AIRN3	Staff supervisions had not been completed across all wards for in some cases over 12 months. Staffing levels and staff skill mix did not meet the trust's minimum staffing levels at times on Ashdale and Elmdale wards at The Dales Hospital and Trinity 1 and Priory 2 at Fieldhead Hospital. This is a breach of Regulation 18 (1)(2)(a)	**Wakefield (Trinity 1 & Priory 2)** Supervision • Copies of staff supervision cards have been distributed to all staff. Staff will be expected to record all evidence of supervision sessions. • Supervision tree for each unit for band 6 and 7 grades and other staff. Supervision will be recorded in each staff file. • We will continue to have group supervision sessions which are facilitated by a psychologist. Staffing levels • We are holding twice weekly whole service staff planning meetings to help in the management of acuity/pressures. • We are using the RAG rating system to identify potential deficits. • We are sharing resources across all units to respond to need. • Use of agency/bank when appropriate.	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		• Central recruitment process to fill staff nurse vacancies (over recruitment agreed). **Calderdale and Kirklees** Staff supervision • We will be reinforcing supervision standards in the Acute Service Line Meeting. • Implement updated supervision policy with staff supervision passport • Implement supervision data base • Monitor team compliance in Service Line **Calderdale (Ashdale and Elmdale)** Staffing levels and staff skill mix • Review of the wards Minimum staffing levels and monthly safer staffing reports • Ongoing work with the Trust's Safer staffing Group to promote safer staffing through recruitment and retention with ongoing monitoring. **Barnsley** Staff Supervision • The BDU will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. • The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by		

Ref	Issue identified	Action	Lead	Completion date
		structured approaches with supervisors the supervisee holds a contract with.		
Specialist community mental health services for children and young people				
CAMRN1	Risk concerns had been documented within the clinical record but not been completed using the appropriate risk screening or comprehensive risk assessment tool in all cases. This was the case at each of the community bases. Following assessment and placement upon a waiting list for treatment there was no system to proactively monitor changes in these assessed levels of risk. This was the case at each of the community bases. This is a breach of Regulation 12(2)(b)	We are taking the following actions in response to this regulation: • Implementation of the case recording audit action plan • Implementation of a robust RiO training programme for staff - incorporating guidance/support in completion of comprehensive and risk assessments. • Implementation of a system of case review to proactively manage risk whilst children/young people and their families are waiting. • Implementation of case recording audit requires ongoing support/guidance through staff supervision systems. • A re-audit will also be undertaken by 31 October 2016 - with a specific focus on comprehensive and risk assessment. • Waiting list case review system to be implemented by 30 September 2016. • Progress against action plan led by CAMHS Clinical Governance and Safety Group and routinely reported to Trust Clinical Governance and Clinical Safety Committee.	Deputy Director of Operations	31st October 2016
CAMRN2	Waiting times for treatment were high with an average wait in excess of five months for the Wakefield CAMHS service. The trust could not provide comparable data relating to the Barnsley CAMHS waiting lists. This was because there were problems extracting accurate information. The trust was not regularly undertaking audits to determine new systems and processes were being embedded into practice. This was the case at each of the community bases.	Actions with regard to waiting times include; • Development of shared data set - numbers waiting and average waiting time from referral to choice/initial assessment; numbers waiting and waiting times (0-3 months, 3-6 months, 6-9 months, 9-12 months and 12+ months) from referral to treatment. • Redesign of care pathways to improve process efficiency and service outcomes. This will include review of skill mix. • Implementation of agreed Future in Mind service development plans, specifically in relation to community eating disorder and earlier intervention services. Actions with regard to audit include; • Establish an annually reviewed CAMHS-wide audit programme • Implement the agreed action plan in relation to clinical record keeping	Deputy Director of Operations	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
	Examples of this were the lack of improvement in clinical record standards. Also an admission by a number of staff they were not following the trust lone worker policy and inconsistent understanding of the requirements of the completion and storage of FP10 prescription pads. This is a breach of Regulation 17(2)(a)(b)(c)	Actions with regard to lone working arrangements include; • Review protocols in relation to lone working, specifically in relation to use of the lone worker devices • Implement a robust programme of training regarding lone working arrangements • Undertake an audit of practice against the lone worker protocol Action taken with regard to storage of FP10 prescription pads; • Advice regarding the secure storage of FP10 prescription pads issued by CAMHS Clinical Lead. • Waiting time data available by 29 July 2016 and on monthly basis. • Pathway redesign work completed across all services by 31 October 2016. • Future in Mind plans fully implemented by 30 September 2016. • CAMHS-wide audit programme agreed by 29 July 2016 • Record-keeping action plan implemented and ongoing. • Lone worker protocol agreed and training completed by 30 September 2016 • Audit of lone worker practice completed by 31 January 2017. • FP10 advice issued/completed Progress against action plan led by CAMHS Clinical Governance and Safety Group and routinely reported to Trust Clinical Governance and Clinical Safety Committee.		
Community-based mental health services for adults of working age				
CMHT RN1	The provider did not ensure there was equitable access to psychological therapies across localities or that this was provided in a timely manner. Waiting times to access psychological therapies was high. Within the Barnsley business delivery unit the average wait was 54	**Kirklees Community Services-Adults of Working Age** • Following our transformation process, the psychological therapy resource will be allocated to both the Enhanced and Core Pathways. • The APTS staff will work as integrated team members and be available for not only direct clinical work, but indirect clinical consultation work to ensure care packages are psychologically informed. This will enhance the ability of other practitioners to	Deputy Director of Operations	31st March 2017

Ref	Issue identified	Action	Lead	Completion date
	weeks. Psychological provision to the South Kirklees assertive outreach team was also insufficient. This had the potential to impact upon individual's recovery. This is a breach of Regulation 9 (3) (b)	deliver low level psychological interventions and also improve patients adherence to intervention once psychological intervention commences. • The Assertive Outreach teams will no longer exists as discrete teams but will be incorporated into the Enhanced Pathway where the Flexible Assertive Community Treatment function will provide intensified input where clinical need dictates. This will include psychological therapy and Psychological Therapy consultation where appropriate. • The trio will work closely with the psychology leads to develop a pathway that will adhere to the 18 week pathway where resources are available. **Calderdale** psychological services are not fully funded to deliver services. In this instance there are discussions with the commissioners for appropriate funding to deliver services. The Transformation model will be delivered against a tight implementation plan which will incorporate reviews at three monthly intervals. Flexibility will be built into the model to allow for flexible realignment of all resources but in particular APTS. The programme will have the 18 week Psychological Therapy referral to treatment embedded within it to ensure performance currently at 98% is maintained. **Barnsley Community Services-Adults of Working Age** Within Barnsley additional capacity is being provided through the following actions: • An additional 3.5 therapy posts will be recruited bringing the total up to 14. Posts are currently out to advert and new staff are expected in post by November 2016. Efficiencies are being introduced: • Increased use of group interventions: A Behaviour Therapy skills group and a Mindfulness Based Cognitive Therapy group have been		

Ref	Issue identified	Action	Lead	Completion date
		introduced. • Aligned pathways with IAPT to ensure those whose needs can be managed outside specialist services receive the appropriate care (from September 2016) • Managed Clinics (Lean principles) to replace clinician/admin led process (from September 2016) • An innovative 3-stage recovery pathway (stabilisation/treatment/recovery) aims to provide meaningful support to people waiting for therapy, including interventions to support stabilisation and to help people prepare for therapy Managing the backlog: We are confident that our plans can deliver productivity at a level that meets demand but we have a significant backlog to address. A proposed solution based on a non-recurrent resource is under discussion with the CCG. **Wakefield Community Services- Adults of Working Age** Wakefield have 100% of individuals assessed within 14 days and 100% receiving treatment within 18 weeks.		
Community-based mental health services for older people				
OCMH RN1	Patients were not able to access services in a timely manner. Referral to treatment times exceeded the 18 week target. This is a breach of regulation 9(1)(b	Within our CQC report it was noted that Barnsley and Kirklees Outreach Team were meeting their referral to treatment time's targets. This information was accurate. However, the referral times figures for North Kirklees CMHT and Ossett CMHT were inaccurate and should have stated that referral to treatment times to North Kirklees CMHT was 69 days and to Ossett CMHT 53 days. Therefore all of our teams were meeting the 18 week target. This was explained within our Factual Accuracy Comments following receipt of our draft report, when we said the figures provided at the time of the visit had been miscalculated by the CQC inspector. However, our comments were rejected.	Deputy Director of Operations	Complete

Ref	Issue identified	Action	Lead	Completion date
		Because of the above we are not in breach of the HSCA Regulations 2014 in relation to this specific matter and will strive to continue to maintain and improve our existing standards. As was explained within the CQC report, we continue to respond to risk in a timely manner to make sure our service users receive a safe and responsive service to meet their personalised needs		
Community mental health services for people with learning disabilities or autism				
LDCRN1	We found that waiting times to access psychological therapies was high. This had the potential to impact upon individual's wellbeing. This is a breach of Regulation 9 (3) (b)	Access to Psychological therapies is split into two pieces of work:- **Reducing waiting times for Autism Assessments – Trust wide** • Review existing clinical pathways for diagnosis of Autism Spectrum Conditions (ASC) across the Trust and align to most recent professional and clinical practice guidance for efficient diagnostic procedures. (Apply a tiered approach: Screening, Interview, Observation, MDT discussion). **(Improved Efficiency; Evidence Based Practice)** • Conduct skills analysis of the learning disability MDTs with a view to broadening responsibility for autism diagnosis to the whole clinical MDT rather than solely with clinical psychology services. **(Better Resource Utilisation; Increased Efficiency)** • Establish a robust, multi-disciplinary, ASC diagnostic assessment clinic drawing on clinical resources from across the whole Trust (rather than solely within localities). **(Improved coordination; Increased Efficiency; Better Resource Utilisation)** **Reducing waiting times for Psychological Therapies in Wakefield community team** • More robust application of the eligibility criteria for accessing specialist psychological services for adults with learning disabilities is being adhered to. **(Demand Management: Better aligning of resources with demand for specialist LD services)** • The existing waiting list is being reviewed and triaged by the Wakefield Psychology Team to ensure appropriateness of cases currently waiting for services. **(Demand Management: Clinical**	Deputy Director of Operations	30th September 2016

Ref	Issue identified	Action	Lead	Completion date
		assessment & review to ensure services are provided and offered to those most in need) • The caseloads of Postgraduate Psychologists in Clinical Training working in the Wakefield psychology service will be increased in line with other departments in the Trust. This work will continue to be overseen by a qualified clinical psychologist with appropriate supervision training and skills. **(Increased activity: Improved resource utilisation – increased number of psychological therapy and assessment sessions available)** • Recruitment of a new full-time Assistant Psychologist to the Wakefield community team is underway. This will assist greatly in increasing the number of available *assessment* sessions provided by the service and in turn release some capacity in qualified clinician time to offer increased sessions of psychological therapy. **(Increased Activity: Number of sessions of psychological assessment and therapy will increase and in turn reduce waiting times)**		
LDCRN2	We found that the use of key performance indicators was inconsistent across the service. Teams co-located in local authority teams were not required to provide KPI information beyond the use of CQUIN outcomes to enable the trust to monitor and improve the quality and safety of the services. This is a breach of Regulation 17 (2) (a)	All Learning Disability staff in integrated teams will come back under the line management of SWYPFT and record on RiO by end of Quarter 3 to enable more effective information to be provided against KPI's	Deputy Director of Operations	31st December 2016
Forensic inpatient/secure wards				
FRN1	We found that there was not enough nursing staff to ensure that important nursing tasks were completed. • Meaningful activity targets were not being met.	**Meaningful Activity:** The current process of reporting will be reviewed: A task and finish activity will raise awareness across the service about the importance of meaningful, recovery based activity and how to record this effectively. 100% activity levels will be achieved. To be	Deputy Director of Operations	31st March 2017

Ref	Issue identified	Action	Lead	Completion date
	• There was a high level of bank and agency staff used who were unfamiliar with the wards. • Data provided by the trust showed that the wards were regularly breaching their own targets on minimum staffing levels. • Patients we spoke to told us there was not enough staff and too many agency workers. • There was no long term plan to resolve the staffing problems. This meant that patient activities and leave entitlement were often cancelled due to the lack of staff. This was a breach of regulation 18 (1)	linked to the Forensic Induction Programme. **Safer Staffing:** This is the long term plan that the service has been working to: • There is a Trust Group for Safer Staffing which the Forensic Services attend. • There is regular monitoring of safer staffing levels. • There are Workforce Meetings for the Forensic Services held 2/52. • A Business Case is being developed to address deficits in the Women's Service and improve the establishment to meet need. • Sickness / absence management is robust. • There is an ongoing programme of over recruitment to offset ongoing fluctuations in establishment. • The Forensic Service is currently managing through a process of workforce re-design with emergent band 2 opportunities and band 4 developments. • Bank shifts are being paid at an enhanced level between the months of June and September to attract regular staff and reduce agency use. • The long term plan is the have a sustainable workforce establishment which does not require agency use to achieve normal business. • Acuity will continue to be managed on a needs basis. • Maximising resources through efficient utilisation of experience and skills across the service. • There are national targets for the reduction of agency use. All the above work will contribute to the reduction in the agency use. A reduction in agency use will ensure that access to patient records is available for the majority of staff in order to provide safe patient care. Electronic Clinical Record (RiO) training is being implemented for regular agency staff, to ensure they can more effectively meet patient need, than relying on supported access through regular staff. • A therapy services review is underway and this will help to maximise use of resources. • A management and administration review is also underway to support the process. • Improving communication and engagement with staff to ensure they		

Ref	Issue identified	Action	Lead	Completion date
		are updated effectively of plans and how issues are being addressed		
FRN2	We found that medicines were not being stored in a safe way. • The temperature recorded in the clinic room regularly exceeded the maximum level. • There was no climate regulation in the clinic room. This meant that medicines were not being stored at the correct temperature to maintain their stability and effectiveness. This was a breach of regulation 12 (2) (g)	This issue was specific in one of the 12 clinic rooms in relation to temperature recordings. This particular clinic is on a 6 bedded pre-discharge area and only contains the medicines for one service user as all others are self-medicating. All clinics are recording temperatures which are safe for the storage of medicines. (Risk Management of Medicines stored in Clinical Areas. Temperature Control Edition 1 2015. NHS Pharmaceutical Quality Assurance Committee 2015). It is recognised higher temperatures for one week consistently may reduce the expiry date by a two weeks. However all medicines are cycled quickly and tend to be used well in advance of the expiry date, therefore this is not a risk. We are continuing to maintain and look at ways of improving our existing standards around storage of medications. We are looking at the following additional options in order to achieve this: • The use of a smaller fridge = reduced heat radiation. • Air conditioning installation. • Improved ventilation. • Alternative storage arrangements for the medication.	Deputy Director of Operations	31st August 2016
FRN3	We found that patients with learning disability or autism did not have positive behaviour support (PBS) plans or equivalent. • Care records showed that very few patients had PBS plans or equivalent. • The trust had not implemented PBS plans or equivalent until recently. • Staff showed a lack of knowledge and understanding of PBS plans or equivalent. This meant that patients with learning disability and autism were not receiving the correct care and treatment as recommended by the Mental Health Act Code of Practice.	• A briefing paper is being developed for staff, outlining what Positive Behaviour Support Plans are and their benefits to service users. • All plans will be clearly labelled as PBS plans.	Deputy Director of Operations	31st October 2016

Ref	Issue identified	Action	Lead	Completion date
	This was a breach of regulation 9			
FRN4	We found that there were no effective systems in place for the trust to maintain oversight in relation to staff training and staff supervision. • The trust did not collate figures on Mental Health Act, Mental Capacity Act and immediate life support training at a governance level. • The trust did not record data regarding staff supervision rates at a governance level. This meant that the trust was not assured that staff were adequately trained or supervised. This was a breach of regulation 17 (2) (a)	• The Trust has made MHA, MCA and Life Support Training Mandatory for all staff. This will enable staff to inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA Code of Practice, and also support appropriate recording as per the Code of Practice, for people in long-term segregation. This will support that consent and capacity to consent should be assessed and recorded in patient notes in accordance with the MHA Code of Practice. • Achievement of training for the service will monitored in Forensic BDU monthly meetings and action implemented to ensure this is consistently achieved. • The BDU will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. • The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by structured approaches with supervisors the supervisee holds ma contract with.	Deputy Director of Operations	30th November 2016
Wards for older people with mental health problems				
OIRN1	On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk	**Wakefield (The Poplars and The Chantry Unit)** 1. The ward managers at the Poplars unit and the Chantry Unit have undertaken an assessment to look at the use of the observation mirrors within the unit. This has resulted in additional mirrors being used for observation purposes. The actions that have been agreed will be completed by no later than 31/7/16 2. The Chantry Unit will be moving to new premises from 5/8/16. Contingencies will be put in place (described below) immediately and will continue after the move, an assessment will be carried out on	Deputy Director of Operations	31st August 2016

Ref	Issue identified	Action	Lead	Completion date
	assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patient s and staff. This was a breach of regulation 12(2)(b)	7/7/16 of the new Chantry premises with the Estates Planning Manager to enable an appropriate level of observation mirrors to be implemented ready for the move of premises. 3. Additional risk assessment information has been added to the existing assessment. The environmental risk assessment record is now to include checking of all areas of the ward including blind spots as part of the 60 minute environmental observations record. 4. Specific environmental risk assessments are to be completed of all areas of wards to include blind spots. 5. An environmental safety care plan has been developed. 6. Changes have been made to the observation policy so that staff have clear guidance about the changes to the observation processes. **Kirklees (Ward 19)** 1. Estates are to undertake a review of ligature safe options for providing clear lines of sight. 2. Ward risk assessments will be undertaken to include consideration and mitigation of environmental factors impacting on service user risk. 3. Improve line of sight by installing mirrors in required areas.		
OIRN2	On Ward 19 the bedrooms door handles were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. This meant that if patients were a high risk of self-harm they would need to be nursed on close observations which was not the least restrictive option. Furthermore this meant that patients who had no previously identified risk of self-harm were not routinely risk assessed for the ligature risk inside their bedroom leaving them with easy access to ligature points.	We have reduced the ligature risk by replacing bedroom door handles. Trust wide review has been completed and a preferred product agreed.	Deputy Director of Operations	31st December 2016

Ref	Issue identified	Action	Lead	Completion date
	This was a breach of regulation 15(1)(C)			
Long stay/rehabilitation mental health wards for working age adults				
LSRN1	We found that at Enfield Down the clinical team did not undertake regular reviews of patient risk assessments following incidents or when there was a change in presentation. They did not undertake physical health monitoring including electrocardiograms for patients prescribed high dose antipsychotic medication. This is a breach of Reg 12(2)(a)(g)	• Individual risk assessments will be undertaken as part of the care planning approach, regular care reviews, MDT meetings and discussed with staff within their individual supervision sessions. • Risk assessments will be developed in a person centred way to meet the patient's individual needs as required. • Risk assessments will be updated as individual's circumstance change. • Senior staff nurses will undertake a weekly medicine management review so that physical monitoring takes place and appropriate actions can be taken as needed to address any concerns within a timely manner. • A member of staff is to receive specialised training in relation to electrocardiograms.	Deputy Director of Operations	Completed
LSRN2	We found that at Enfield Down did not undertake regular MDT reviews to ensure timely and appropriate treatment plans. This is a breach of regulation 9 (1)(a)(b)	• The Community Service Manager has nominated an identified Care coordinator for all in-patients at Enfield Down. This person will attend all MDT meetings and be responsible for co-ordinating all patients' CPA reviews • Confirm the availability of medical staff to attend the MDT meetings or make alternative arrangements if there are difficulties with this to ensure there is medical input into the meetings.	Deputy Director of Operations	Completed
LSRN3	We found that the long stay / rehabilitation service did not have sufficient governance structures in place ensure effective monitoring of the service. The service currently lacked governance lead post and had failed to identify failings in the service.	Leadership of clinical services have been reviewed within the band 6 and band 7 roles and responsibilities. Bands 6 and 7 have taken on individual responsibilities for the 7 pillars of governance and the day to day responsibility for a defined group of service users. We have appointed a full-time Practice Governance Coach who has now commenced in post.	Deputy Director of Operations	Completed

Ref	Issue identified	Action	Lead	Completion date
	This is a breach of regulation 17(1)(2)(b)			
LSRN4	We found that the long stay / rehabilitation service did not ensure staff were adequately trained in the MHA and MCA This is a breach of regulation18 (2)(a)	• The trust has now implemented MHA/MCA as mandatory training. Team managers will received monthly notifications about any outstanding training for staff. The team managers will then ensure staff are booked onto training where this is needed or ask staff to undertake e-learning where applicable. • Ensure all staff retain their individual responsibilities for maintaining up to knowledge and expertise through such avenues as team meetings and supervision processes. • Managers will monitor compliance with the MHA/MCA through daily observations, incidents, service user feedback, audits etc.	Deputy Director of Operations	31st March 2017
LSRN5	We found that at Enfield Down, staff did not ensure that T2 (consent to treatment) forms were completed accurately. This was a breach of regulation 11 (1)	We have developed a written process and guidance for staff to follow to ensure T2 forms are completed accurately. This guidance will be on display in prominent places so the information is easy to access. Remind staff to prompt medical staff to check for accuracy when completing forms so that information is clear and easy to understand.	Deputy Director of Operations	Completed
MUST Dos				
OCMH MUST2	The trust must ensure there is access to crisis services for older people.	**Calderdale & Kirklees BDU** - Kirklees OPS have a team call Kirklees Outreach team who provide an intensive home based treatment model between the hours of 8am & 8pm, 7 days a week. Outside of these hours an all age crisis response is provided by the AWA IHBTT. Calderdale OPS CMHT have dedicated staff who provide an intensive home based treatment model up to 8pm during the week and up to 5pm at weekends. Outside of the hours and all age crisis response is provided by the AWA IHBTT.	Deputy Director of Operations	Completed

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
22 July 2016

Agenda item:	**8**
Report Title:	Annual report, accounts and Quality Accounts 2015/16
Report By:	Dawn Stephenson on behalf of Mark Brooks, Director of Finance, Tim Breedon, Director of Nursing and Professions, Clinical Governance and Safety, and Paul Hewitson, Director, Deloitte
Job Title:	Director of Corporate Development
Action:	To receive

EXECUTIVE SUMMARY

Purpose and format

The purpose of this report is to enable the Members' Council to receive the Trust's annual report, accounts and Quality Accounts for the period 1 April 2015 to 31 March 2016, which were approved by the Audit Committee, on behalf of Trust Board, on 23 May 2016.

Recommendation

The Members' Council is asked to RECEIVE the annual report, accounts and Quality Accounts for 2015/16.

Background

As a Foundation Trust, the Trust is required to prepare an annual report and accounts to meet guidance issued by the Regulator, Monitor. The annual report, accounts and Quality Report are audited by the Trust's external auditors, Deloitte. Under its Constitution, the Trust is required to present its annual report and accounts to the Members' Council at a general meeting.

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 were laid before Parliament on 20 June 2016.

Outcome

Annual report 2015/16

The annual report was developed in line with Monitor's requirements and this was confirmed by the Trust's external auditors. The Audit Committee approved the annual report.

Annual accounts 2015/16

The Audit Committee considered the report from the Director of Finance on the final

accounts (attached for the Members' Council), the Head of Internal Audit Opinion (see below) and the findings of the external auditors, Deloitte (ISA 260 attached for the Members' Council). 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.

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.

The Audit Committee approved the accounts for 2015/16.

Quality Report

As requested by Trust Board, the Quality Report was scrutinised in detail by the Clinical Governance and Clinical Safety Committee prior to its presentation to the Audit Committee and a recommendation made for it to be formally approved. The Quality Report has been published on the NHS Choices website as required.

The external assurance review conducted by Deloitte was received by the Audit Committee on 23 May 2016 (included in these papers for the Members' Council with the Trust's response to audit recommendations). Deloitte was satisfied with the content and consistency of the report.

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.

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 addressed by the end of June 2016.

The Audit Committee approved the Quality Report for 2015/16.

To support this item, the following papers have been sent to the Members' Council and the Trust's external auditor, Deloitte, will make a brief presentation at the meeting on the key points arising from its audit:

- the Director of Finance's report on the accounts for 2015/16;
- the report from Deloitte to those charged with governance (ISA 260);
- the Chief Executive's Annual Governance Statement;
- statements of income, financial position and cash flows for the period;
- the external assurance report on the Quality Accounts from Deloitte; and
- the limited assurance report on the Quality Accounts from Deloitte.

The report from the Director of Finance gives a summary of the financial position at the year-end and the Trust's full annual report and accounts for 2015/16 can be found at Trust annual report, accounts and Quality Accounts 2015/16.

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. • 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. • 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: • Fixed assets, • CQUIN Income, • Leases, • IT findings, and • 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

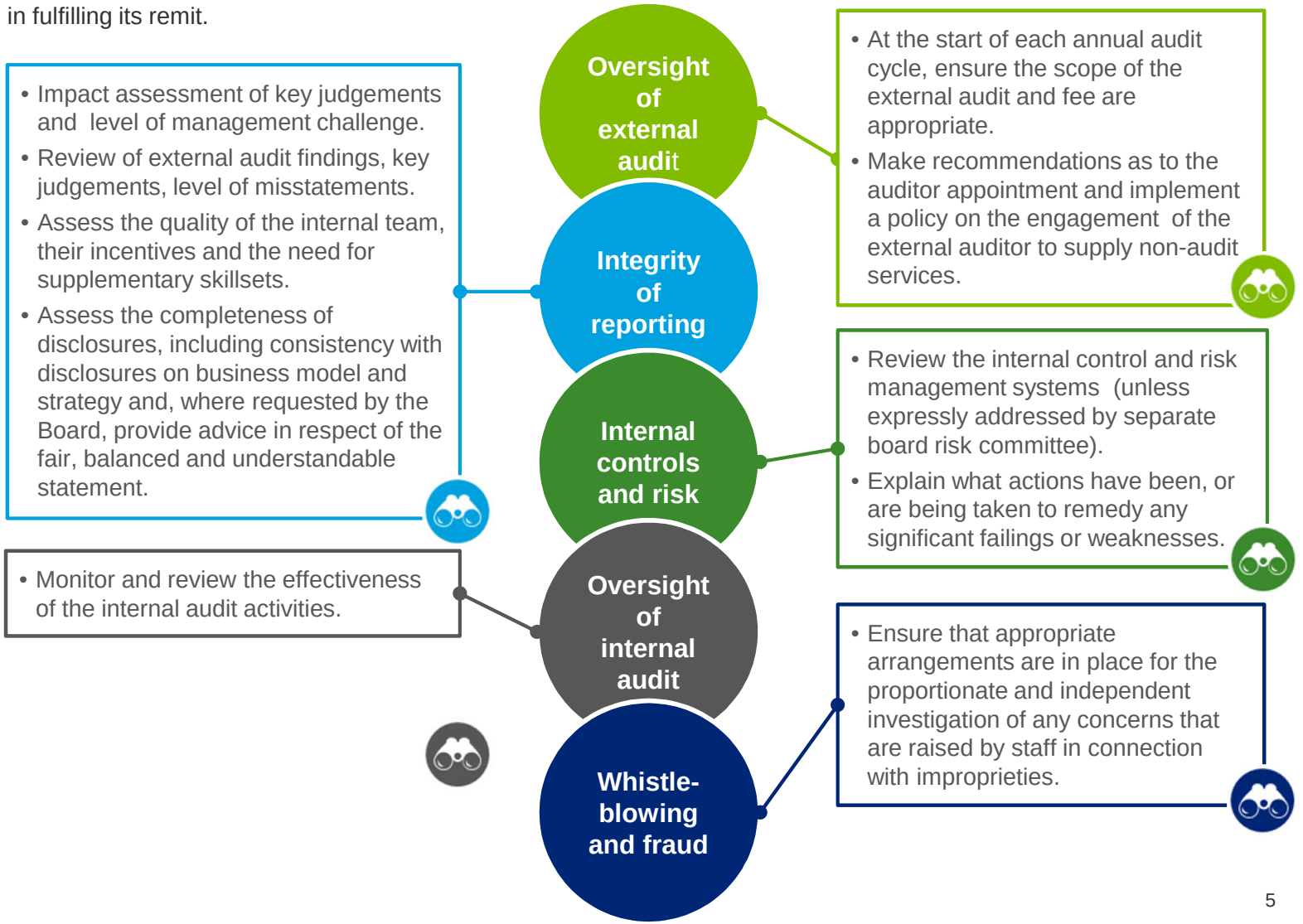
Clearly communicate the planned scope of the financial statements audit

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; • 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; • We reviewed the Q4 estimate of CQUIN income and agreed this to communication with the Commissioners; and 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. 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. • 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. • We assessed the reasonableness of the key assumptions used in the valuation. • We examined the accuracy of the posting of the final valuation to the general ledger and financial statements. • We have examined the independence of the District Valuer and are satisfied with this. 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. • 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. • We reviewed management’s assessment of impairments to the value of cost held in assets under construction. • 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. We are satisfied that the work completed by the District Valuer is of a reasonable standard and that key assumptions are appropriate. 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

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: • the testing of journals, using data analytics to focus our testing on higher risk journals; • significant accounting estimates relating to the estimates discussed above in respect of NHS revenue recognition and provisioning, capital expenditures and property valuations; and • any unusual transactions or one-off transactions including those with related parties. Our wider response to the risk of fraud is set out in the appendix. In considering the risk of management override, we: • assessed the overall position taken in respect of key judgements and estimates; • considered the sensitivity of the financial statements with respect to the achievement of financial performance targets including Financial Sustainability Risk Rating ("FSRR") thresholds; • 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. We have not identified any bias in the selection of accounting estimates nor any significant and unusual one off transactions. 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. 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. 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. 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. 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. • 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: • interviewed senior officers of the Trust subsequent to the visit to understand the high level messages provided; and • 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. • 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. • 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:** • **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;** • **have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and** • **have been prepared in accordance with the requirements of the National Health Service Act 2006.** 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 • 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 • we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern. 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 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. 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. 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. We tested the recognition of CQUIN income through the year by: • Confirming the amount of CQUIN income available to the underlying contract; and • 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 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. 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. 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. 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 During the year two major capital projects, Laura Mitchell House and New Street, were completed and the assets brought into operational use 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. 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. • We tested, on a sample basis, the accumulation of cost into the balance of assets under construction. • 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. • 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. 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. 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. 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. 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. 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. The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems. 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. 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: • the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006, and • 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: • 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; • the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or • proper practices have not been observed in the compilation of the financial statements. We have nothing to report in respect of these matters. 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: • materially inconsistent with the information in the audited financial statements; • apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or • otherwise misleading. 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. 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. **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. **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. **Advocacy threat:** We are not proposing to act as Trust advocate in any capacity. **Familiarity threat:** We are in compliance with the independence requirements concerning rotation. **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 **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. **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. **Advocacy threat:** We are not proposing to act as Trust advocate in any capacity; the proposal is to advise not to act. **Familiarity threat:** We are in compliance with the independence requirements concerning rotation. The advisory team is also independent of the Trust. **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 **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. **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. **Advocacy threat:** We are not proposing to act as Trust advocate in any capacity; the proposal is to advise not to act. **Familiarity threat:** We are in compliance with the independence requirements concerning rotation. The advisory team is also independent of the Trust. **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.

Annual Governance Statement 2015/16

Scope of responsibility

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

The Annual Governance Statement reflects the challenges and changes facing the Trust over the past year and demonstrates the complexity and diversity of the services the Trust provides and the geographical areas it covers. This presents a unique challenge for the Trust, which is reflected in its approach to the management of risk.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the Trust's strategy and objectives, ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is prudent and pragmatic, adopting a flexible approach to risk and determination of its response as the need arises. The Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time.

The Trust has robust arrangements and frameworks in place to ensure it has the capacity to handle and manage risk. One of the principal strengths for the Trust in this regard has been the leadership and stability of its Board. Over the last year, we have seen some considerable change, both for Non-Executive and Executive Directors, which has been managed in a way to minimise disruption and maintain the consistency of leadership.

In the Annual Governance Statement for 2014/15, we reflected on the challenge in terms of changes to Non-Executive Directors on the Board in the coming year as two experienced and long-standing Non-Executive Directors would come to the end of their terms of office

during 2015. One of the key considerations for the Nominations Committee, which has devolved responsibility from the Members' Council to oversee and manage the process to appoint the Chair and Non-Executive Directors, was to ensure effective succession planning with minimum disruption to the stability of the Board. As a result, the Committee sought to appoint two individuals with the skills and experience to ensure the Board retained the skill-set of departing Non-Executive Directors.

Given the calibre of the candidates interviewed, the Nominations Committee approved a recommendation from the interview panel to appoint three candidates. It was considered that all would bring something different and add value to the Board, which was particularly appropriate given the challenge and volume of work currently for Non-Executive Directors. The Members' Council approved the appointments and the new Non-Executive Directors joined the Trust on 1 May, 1 August and 1 October 2015. There has been a successful and smooth induction and transition, which has minimised any risk to the organisation.

Given the significant change to the membership of the Board, the Members' Council also approved the re-appointment of one non-executive director, who had already served two terms of office, for a further year to continue to provide stability and strength within the Board.

Following my predecessor's decision to take voluntary early retirement on 31 March 2016, the Chair instigated a robust and challenging recruitment process for a successor who would continue to drive the Trust forward as a successful values-based organisation. This culminated in my appointment. I joined the Trust from my role as Chief Executive of the NHS Confederation from 16 May 2016. In the interim, the Deputy Chief Executive acted as Chief Executive with appropriate cover arrangements in place.

During the year, the Remuneration and Terms of Service Committee also considered a proposal to split the role of Deputy Chief Executive/Director of Finance. In the current challenging times both internally and externally, the planning, contracting and commercial aspects of the Deputy Chief Executive role were becoming increasingly important and demanding in terms of capacity and involvement, which could, potentially, have an adverse impact on the finance function. An interim Director of Finance was appointed on 4 January 2016 to fulfil this role. A substantive recruitment process resulted in the appointed of Mark Brooks who will join the Trust on 1 June 2016.

This year also saw the decision of the Deputy Chief Executive to seek early retirement from the Trust at the end of May 2016. This presents a risk to the Trust in terms of stability and continuity and the Board had every confidence that this could be managed, particularly as the remaining members of the Executive Management Team have the skills and experience to mitigate and robustly address any risk to the Trust.

During the year, the changes initiated in 2013 to the Director structure at operational level continued to develop. The structure ensures strong and effective strategic and operational management is in place within each BDU whilst maintaining a strong local focus. Deputy directors are now in place across all Business Delivery Units (BDUs) 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 year also saw the embedding of arrangements at service line level to provide the leadership and management framework 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.

Further improvements have been made to strengthen leadership in critical areas. Following an interim appointment at Director-level to cover child and adolescent mental health

(CAMHS) and forensic services, with the support of the Remuneration and Terms of Service Committee, a permanent post was established to cover forensic and specialist services at BDU Director level with an appointment from 21 March 2016. The interim management of CAMHS provided focussed operational support at Director level to take forward the recovery plan agreed with commissioners in Calderdale and Kirklees. The Trust Board has scrutinised implementation of the plan through the year. It agreed in December 2015, given the progress the Trust had made in this area, that continued monitoring and assurance would be provided through the Clinical Governance and Clinical Safety Committee.

During the year, the Trust has also sought interim support at Director-level for engagement, marketing and commercial development.

Although a prudent approach has been adopted in relation to Director-level appointments over the past year, in consultation with the Chair, the Trust continues to face a challenging and difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. To meet these challenges, the Trust Board structure will continue to be reviewed to ensure it has the capacity, skills and experience in place within the parameters of its Constitution to support sustainability and ongoing fitness for purpose.

The Trust Board continues to be ably supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has gone from strength-to-strength in its ability to challenge and hold non-executive directors to account for the performance of the Trust Board. The agendas for Members' Council meetings focus on its statutory duties, areas of risk for the Trust and on the Trust's future direction. The Trust continues to develop its approach to training and development to ensure governors have the skills and experience required to fulfil their duties in partnership with the Members' Council Co-ordination Group.

The Trust continues to lay the foundations for its ambitious service change programme and to develop associated structures to transform the way it delivers services. The programme will ensure the Trust continues to deliver services that meet local need, offer best care and better outcomes, and provide value for money whilst ensuring the Trust remains sustainable and viable. Implementation of the programme as well as maintaining delivery of high quality and safe services has, again, presented the Trust with its biggest challenge in 2015/16. Four workstreams provide the framework, covering mental health services, learning disability services, general community services and forensic services. Each has a Director sponsor and clinical lead and is supported by robust project management arrangements through the Project Management Office. Although the scale and pace has made it hard to effect and enact fundamental change during the year, the work to develop the framework holds the Trust in good stead to achieve the pace of change needed during the coming year.

The strategic framework for the organisation provides a mechanism for principal objectives to be agreed and set by the Board, underpinning the Board assurance framework and implementation objectives determined in line with key executive director accountabilities. These objectives were reviewed by my predecessor with individual directors on a quarterly basis. Any resulting amendments to the Assurance Framework were reported directly into the Trust Board including any changes to the organisational risk register.

The articulation of 'How the Organisation Runs' sets out the Trust's mission and strategic objectives, clarifies the roles and responsibilities at every level of the organisation to deliver continued success, and sets out a clear and simple model to describe the systems we operate within and how they interact, enabling the organisation to run to best effect. The model is based on the work of Dartmouth Institute in the USA, most notably, Dr Gene Nelson, who, through our ongoing relationship with Jönköping County Council in Sweden, provided the basis for this model.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation by having robust service delivery arrangements. This is executed through an appropriate scheme of delegation and standing financial instructions. This year has seen further development and embedding of the BDU operational and governance arrangements, underpinned by service line management and currency development at service delivery level. Development work continues to progress, closely scrutinised by the Audit Committee.

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

- financial management;
- information and performance management;
- people management;
- estates management;
- compliance, governance, communications, engagement and public involvement; and
- health intelligence and innovation.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers. This is through initiatives such as Creative Minds and the development of a recovery approach and recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

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

The Chief Executive has a duty of partnership to discharge and to ensure the Trust works collaboratively with other partner organisations. The Trust recognises that, in the medium- and longer-term, services across the local health economy need to change to drive improvements in care and meet the needs of changing and diverse populations. The current financial pressures across the NHS and care system meant they are not sustainable in their current form. The Trust is deeply committed to partnership and has to work with other organisations to ensure that services are provided in the most effective way for the benefit of people who use our services and that the Trust remains sustainable and viable.

The Trust has sound and robust partnership arrangements with the four local authorities in Barnsley, Calderdale, Kirklees and Wakefield and the five clinical commissioning groups covering Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield. Relationships have been fostered, developed and built on with commissioners. The Trust also has good working relationships with Local Area Teams at Director and senior management level. The relationship with the Secure Commissioning Group, covering the Trust's medium and low secure services, has again proved challenging during 2015/16 as national policy affects commissioning intentions locally. This has impacted on the Trust's forensic services, and maintenance of sound relationships locally is a critical factor in supporting the future success of these services.

All Executive Directors are fully engaged in relevant networks, including safeguarding boards, health and wellbeing boards, quality governance boards, nursing, medical, finance

and human resources at local and regional level. The Trust is represented at Chair and Chief Executive-level at national network meetings and my predecessor was the Chair of the NHS Confederation Mental Health Network Board and a Trustee of the NHS Confederation. The Trust Chair is a member of the NHS Providers Board, the trade body for NHS providers of services.

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

The risk and control framework

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS Foundation Trust condition 4, which applies to Foundation Trusts only.

At the end of April 2015, the Trust Board commissioned Deloitte to undertake an independent review of the Trust's governance arrangements using Monitor's well-led governance framework. The Trust Board decided to undertake an independent review at this time as part of the developmental approach to its governance arrangements and to ensure fitness for purpose as the Trust moves to the next challenging phase. At the time, the Trust had not yet been scheduled for a full Care Quality Commission inspection. The outcome of the review was presented by Deloitte to Trust Board in July 2015 and formally presented at the public session of the Board in September 2015 and the Members' Council in November 2015. Deloitte also facilitated a joint session for Trust Board and the Members' Council to undertake further work on action in relation to the recommendations arising from the review.

There were no 'material governance concerns' arising from the review. Trust Board is not complacent, however, as there are a number of developmental areas where Deloitte recommended further work and these form the basis of an action plan with timescales, which Trust Board has taken forward. The process and outcome reflect the developmental approach taken and Trust Board is satisfied with the outcome. The most pleasing aspect for the Board was that the Deloitte report very much reflected its own assessment of the Trust's arrangements and the report provides a series of helpful and constructive recommendations.

The Trust was also subject to an inspection by the Care Quality Commission in March 2016. The inspection team visited all of the Trust's in-patient units, a third of community mental health teams and a cross-section of general community services. The overwhelming feedback from the inspection team chair was that our staff were found to be caring, and this was without exception. The Care Quality Commission was also impressed with how welcoming, helpful, open and honest the Trust and its staff were found to be, as well as how organised. Some notable areas of good practice were highlighted as:

- in general community services, this included the commitment of staff in Barnsley 0-19 service, telehealth and care navigation service, epilepsy service and end of life care service;
- in mental health and specialist services, this included attention deficit hyperactivity disorder service, prison in-reach, community learning disability service, community child and adolescent mental health service and older people's wards.

There were also some areas of concern, most of which the Trust is aware of and has mitigating action in place to address the issues. This included:

- safer staffing, particularly on acute wards;
- monitoring of care and treatment in rehabilitation services (mental health), particularly at Enfield Down;
- Mental Health Act and Mental Capacity Act training and recording of it taking place;
- waiting lists for child and adolescent mental health services and psychological therapies; and
- physical health monitoring.

The report will be sent to the Trust in May 2016 to check for factual accuracy with receipt of the formal report on or around 7 June 2016. This will be followed by a Quality Summit later in the summer.

As Chief Executive, I remain accountable and ensure that my accountabilities are secured through delegated executive responsibility through the Executive Directors of the Trust for the delivery of the organisational objectives. This is achieved, while ensuring there is a high standard of public accountability, probity and performance management. In 2015/16, my predecessor set personal objectives for each director that had clear risk and assurance statements attached to them. These were reflected in the Assurance Framework through the strategic objectives assigned to each Director.

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

Strategic risk is managed in line with the Trust's Risk Management Strategy, which was amended and approved by the Trust Board in January 2016 to ensure it remains fit for purpose. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in accordance with the principle to reduce risk to as low a level as reasonably practical. The Trust's risk matrix sets out those risks which, under this principle, are tolerable from those which are unacceptable.

The Trust has an organisational risk register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team and quarterly by Trust Board, providing leadership for the risk management process. Risk registers are also developed at service delivery level within BDUs and within support directorates, again being subject to regular reviews in line with Trust's Risk Management Strategy and monitored monthly by EMT. The opportunity to share concerns and good practice is facilitated through BDU governance groups led by District Directors.

The Trust's main risks in 2015/16 as set out in the organisational risk register were as follows.

1. Risk of adverse impact on clinical, operational and financial risk if the Trust is unable to manage the transition in year 3 of the five-year plan as the plan states that the Trust would be operationally, clinically and financially unsustainable by the end of 2016/17 in its current configuration.
   Mitigated by active stakeholder management to create opportunities for partnership and collaboration, development of 'preferred partner' arrangements, robust monitoring by the

Executive Management Team and Trust Board, recruitment to key areas of expertise to realise the five-year plan through health intelligence, marketing and commercial skills, increasing use of service line reporting to inform service decisions and increase in joint bids and projects to develop strategic partnerships.

2. Risk that the planning and implementation of transformational change through the transformation programme will increase clinical and reputational risk in in-year delivery, particularly through skills and capacity to balance the 'change job' and the 'day job'.
   Mitigated by staff engagement strategy in place with implementation plan, director objectives specifically linked to manage the risk, regular monitoring by the Executive Management Team and Trust Board and a well-established quality impact assessment process in place.

3. Risk that the planning and implementation of transformational change through the transformation programme is not aligned to NHS and local authority commissioning intentions and will increase clinical, operational, financial and reputational risk through potential implementation of service models which are not supported by commissioners.
   Mitigated by development of an engagement plan with stakeholders, active participation in service integration initiatives across the Trust's districts, development of stronger links with national bodies to influence local and national agendas in relation to mental health, strengthening of the link between transformation and contracting and agreement of number of key transformation projects supported by commissioners and local authority Overview and Scrutiny.

4. Risk that the impact of continued reduction in local authority budgets may have a negative impact on the level of financial resources available to commission services from NHS providers, which represents a clinical, operational and financial risk, in particular for services commissioned by public health.
   Mitigated by monitoring through BDU/commissioner forums, and joint working and development of joint approaches with local authorities.

5. Risk that the Trust's clinical, operational and financial sustainability will be adversely affected in 2016/17 by the impact of local commissioning intentions from clinical commissioning groups and local authorities.
   Mitigated by proactive involvement in system transformation programmes, internal transformation programme linked to commissioning intentions, planned improvement in bid management processes and horizon scanning for new opportunities, increase in capacity and skills to support stakeholder engagement, maintain robust controls on costs to maximise contribution and alignment of commissioning intentions with strategic plan for 2016/17.

6. Risk that continued reduction in local authority funding and changes in the benefits system will result in an increased demand for health and social care services, which may impact on the capacity of Trust services.
   Mitigated by monitoring through BDU/commissioner forums, joint working and development of joint approaches with local authorities, and weekly risk scan by Director of Nursing and Medical Director.

7. Risk that implementation of new currency models moving current funding arrangements from block contracts to activity-based contracts may present clinical, operational and financial risk if cost and pricing mechanisms are not fully understood.
   Mitigated by inclusion of currency modelling in mental health transformation projects, contract agreements and monitoring in place with commissioners, monitoring at service line by 'trios' within services, and ongoing monitoring and scrutiny through the Executive Management Team, the Audit Committee and the Operational Requirement Group.

8. Risk that capture of clinical information on the Trust's clinical information system will be insufficient to meet future compliance and operational requirements to support service line reporting and implementation of mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.
   Mitigated by Systems Development Board in place led by Director of Nursing, additional resources allocated and managed by 'trios' within services, ongoing monitoring and scrutiny by Executive Management Team, Audit and Clinical Governance and Clinical Safety Committees, and action plan in place to address five priority areas.

9. Risk that bed occupancy above that expected as a result of increase in acuity and admissions is causing pressures across bed-based services across the Trust.
   Mitigated by bed management systems in place across all BDUs to manage patient flow, reduce out-of-area placements and reduce delayed discharges of care, weekly situation reports to assess the position at the Operational Requirement Group, internal audit undertaken on implementation of bed management protocol with action plan in place, and Trust-wide bed position available to all relevant staff to enable effective use of Trust bed-base.

10. Risk that upgrade to the Trust's clinical information system, RiO, which resulted in system functionality and operational issues, will impact on the Trust's ability to effectively support clinical services operationally, in the production and submission of central returns and accurate recording of clinical coding information.
    Mitigated by robust processes in place to review and monitor progress resolution at a senior level and to manage effective communications, daily contact with system supplier regarding issue resolution and progress, internal investigation complete with report to be presented to the Executive Management Team, external, independent review to be commissioned by Director of Corporate Development and weekly monitoring of issues at both Executive Management Team and Operational Requirement Group.

11. Risk that, in 2016/17, the Trust will be unable to secure sufficient funding to support a sustainable child and adolescent mental health service.
    Mitigated by the introduction of 'summit' meetings during 2015/16 involving local commissioner and local authority representation, review through regular contracting meetings and Quality Board, development of a robust recovery plan monitored by Trust Board and joint work in place with commissioners as part of 2016/17 contract negotiations.

12. Risk that the increase in reported information governance incidents to the Information Commissioner will impact on the Trust's reputation.
    Mitigated by additional action taken to review guidance and policies, targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents, awareness raising sessions in place at all levels in the organisation, re-branding of materials and advice for staff and increase in availability of training for staff.

Given the strategic context within which we operate, the risks outlined above will continue into 2016/17 with mitigating action in place. The creation of Sustainability and Transformation Plans (STP) across West and South Yorkshire will provide a further mechanism for managing risks. As the lead Chief Executive for the STP in West Yorkshire, I will be able to ensure we are closely engaged in the leadership and delivery of these plans.

Innovation and learning in relation to risk management is critical. The Trust uses an e-based reporting system, DATIX, at Directorate and service line level, so that incidents can be input at source and data can be interrogated through ward, team and locality processes. This encourages local ownership and accountability for incident and risk management. The Trust

identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors. The Trust operates in a way that is guided by its values and has a just, honest and open culture where staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes.

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

The Trust works hard to provide the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This communication is open, honest and occurs as soon as possible following a patient safety event. The Trust's duty of candour is taken extremely seriously and a robust approach is in place to ensure staff understand their role in relation to duty of candour, that they have the support required to comply with the duty and to raise concerns, that the duty of candour is met through meaningful and sensitive engagement with relevant people, and all staff understand the consequences of non-compliance.

The Clinical Governance and Clinical Safety Committee scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Mazars report on Southern Health NHS Foundation Trust, the national audit of schizophrenia and the Lampard Report. The Committee oversees all work until actions have been completed and closed. The Clinical Review Group, chaired by the Director of Nursing, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation.

The provision of mental health services carries a significant inherent risk, resulting, on occasion, in serious incidents, which require robust and well governed organisational controls. During 2015/16, there were 76 serious incidents across the Trust compared to 106 in 2014/15. This reflects changes to reporting of serious incidents in relation to pressure ulcers. The Trust reports only those attributable to the Trust that are deemed as being avoidable. This has resulted in a significant reduction in the number of serious incidents. Overall, the underlying trend is stable. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risk that impacts on them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups, public involvement in the activities of our Trust, membership of the Trust and its Members' Council, and regular dialogue with MPs and other partners.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring Equality Impact Assessments are undertaken and published for all

new and revised policies and services. Any new or revised polices, strategies, service re-design and projects must undertake an Equality Impact Assessment before approval. This ensures that equality, diversity and human rights issues, and service user involvement are systematically considered and delivered on core Trust business. All commissioned services also have an Equality Impact Assessment. The Equality and Inclusion into Action Group ensures EIAs are fully mainstreamed into BDUs' performance framework.

Early in 2015, Trust Board established an Equality and Inclusion Forum to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. The Forum develops and oversees the strategy to improve access, experience and outcomes for people from all backgrounds and communities including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. Staff survey results in 2015/16 show improvements for BME staff.

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

South West Yorkshire Partnership NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and a regular programme of unannounced visits. The experience gained from visits reinforces the organisational value of conducting the programme. Visit team findings facilitate learning and provide teams with useful experience of an inspection process. Feedback reports are received and reviewed by BDUs with direction for action focused through BDU governance functions. Lessons learned from the process are used to inform changes to the next planned visit programme. In preparation for its inspection visit in March 2016, the programme focused particularly on assessment against both the CQC essential standards and the Trust's quality priorities.

The Trust assesses itself annually against the NHS Constitution and a report was presented to Trust Board in September 2015. This covered all areas of the Trust. The Trust meets the rights and pledges of the NHS Constitution. The Trust considers that there are elements of the Constitution that refer to consultation and involvement with service users that need moderation for mental health service users. The Trust is firmly committed to consult and involve all service users and, where appropriate, their carers, in decisions about their care. However, there may be occasions when the nature of an individual's illness makes this inappropriate, such as if they lack capacity.

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

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Improvement Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust

Board, co-ordinated under the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.

- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The Trust has also signed up to the national 'Sign up to Safety' initiative and will deliver against a specific safety improvement plan over the next three years.
- There are quarterly quality reports for Trust Board and the Executive Management Team as well as monthly compliance reporting against quality indicators within performance reports. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of ECT, PICU and Memory Services, CQC Mental Health Act Visits, national surveys (staff and service user), implementation of Essence of Care and Productive Ward, etc.)
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as serious incidents, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.

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

- Systematising the collection of service user and care feedback through kiosks and hand held tablets, with a consistent approach to action planning and communication of the response to feedback, including assessment against the Department of Health's Friends and Family Test.
- Review and implementation of the '15 Steps Challenge' across the Trust involving service users and carers, and stakeholders, including staff.
- Insight events for members and the public held twice a year.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's transformation programme.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- Principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.

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

The Trust holds the Cabinet Office's Customer Service Excellence award.

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

The governance framework of the Trust is determined by Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and

attendance at Trust Board and its Committees, including the Audit and Remuneration and Terms of Service Committees, and the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, through Delivery EMT, BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting. In 2015/16, work has continued to develop and strengthen the Trust's health intelligence function to support development of existing and new services. Work also continues both internally and with partners on the quality, innovation, productivity and prevention (QIPP) agenda.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities whilst aligning Trust plans with commissioning intentions and wider district plans. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

The Operational Requirement Group continues to meet weekly and was able to support implementation of the 2015/16 plan. The Group helps to ensure robust operational management is in place to manage Trust resources and to achieve the targets set out in the Trust's annual plan. The Group is chaired by the Chief Executive, attended by Executive and operational Directors and their Deputies. The Group supports the assurance provided to the Executive Management Team and to Trust Board that there is strong management control over the Trust's resources and that risk is managed and mitigated.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. Quality Impact Assessments take an objective view of cost improvements developed by BDUs on the quality of services in relation to the Trust's seven quality priorities (access, listening to and involving service users, care and care planning, recording and evaluating care, working in partnership, ensuring staff are fit and well to care, and safeguarding). The Assessments are led by the Director of Nursing and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians.

Deloitte was asked to review progress against the recommendations made for the 2014/15 financial plan and to review the plan for 2015/16. Deloitte found that, overall, the process had significantly improved. Development of the cost improvement programme showed a clear bottom/up approach with clear ownership within and by BDUs. The risk assessment was thorough, was a good process, and was seen to be balanced. The depth and detail of the quality impact assessment and quality of challenge was commended and was seen to be rigorous, particularly compared with other organisations. The Quality Impact Assessment process was seen as a well-developed methodology for the Trust to understand the level of risk involved with each proposed cost saving.

In terms of the follow up to the 2014/15 review, the recommendations had been substantially implemented and completed or partially completed. Where only partially completed, this

presented no material weaknesses. For the review of the 2015/16 plan, for the majority of schemes, Deloitte concurred with the Trust's assessment of risk to delivery in terms of outcome; however, by value of savings to be realised, Deloitte considered the risk to delivery to be higher.

Deloitte was again asked to undertake a review of the Trust's Cost Improvement Programme for 2016/17. The draft report was presented to Trust Board in April 2016. Within this review, the auditor concurred with many of the Trust's assessments but recommended a higher risk rating for a number of schemes in the early stages of development. The Trust has established a robust approach for these high risk schemes and has worked with Deloitte to provide management responses to the recommendations highlighted in the report. The Executive Management Team has taken responsibility for the monitoring of progress against these programmes and will maintain a strong focus on delivery in terms of both quality and cost.

During 2015, the arrangements for external and internal audit came to an end. For external audit, the Trust's contract with Deloitte came to an end on 30 September 2015. Following a robust and open procurement exercise against the national framework, Deloitte was re-appointed by the Members' Council as the Trust's auditor from 1 October 2015 for a three-year period.

Although its original intention was to tender for internal audit services during 2015, the Audit Committee took the view that, given the changes within the organisation currently, engendering such a change would present unnecessary risk. As a result, the Committee agreed to extend the contract for KPMG as the Trust's internal auditors for a further year to 30 July 2017.

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

Information Governance

Information governance is a key compliance area for the Trust. Control measures are in place to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust SIRO (senior information risk owner). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2016. To strengthen its arrangements, the Trust's approach in 2015/16 has been to review guidance and policies, take a targeted approach to providing advice and support to staff through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended EMT, re-branding of materials, and offering advice and increasing availability of training for staff. Incidents and risks are reviewed by the Information Management and Technology Trust Action Group chaired by the Director lead for information governance, which informs policy changes and reminders to staff.

Early in 2015/16, the Trust was asked to sign an undertaking by the Information Commissioner's Office due to data breaches under the Data Protection Act 1998 involving staff sending misdirected mail. There were eight incidents of mail being sent to the wrong address recorded during quarter 1 of the year. Action was taken by the Trust, including

communication to all staff highlighting this issue and providing a number of practical steps to follow for all mail going forward. The Information Governance team also launched bespoke training packages to ensure that staff are clear on how information governance relates to them.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office. There have been two such incidents reported in 2015/16. The first related to a complaint received by the Trust from a solicitor acting on behalf of the mother of a child that was a previous service user in relation to an incorrectly addressed letter containing sensitive information. Some of this information was then allegedly uploaded to social media. An investigation was initiated and a number of actions have been taken as a result including a capability review, enhanced staff training and a review of policies and procedures.

The second incident occurred in 2014/15 (although not reported until 2015/16) and related to the disclosure of health records via a 'subject access request' without the prior consent of the data subject. The resulting investigation resulted in a review of Trust procedures to ensure compliance with legislative requirements, bespoke training for individual staff and an enhanced training programme across the Trust.

A further incident has occurred after the end of the reporting period in April 2016 in which letters containing sensitive personal information relating to the physical health of children were sent to the wrong address. This has been treated as a level 2 incident because of the number of cases identified. The investigation is still ongoing. Action has been taken on the initial findings, which indicate that the incident was due to accessing the wrong field from the clinical information system and this has now been rectified.

Investigations into the three incidents reveal that the circumstances are discreet in each instance and do not indicate a systematic pattern of non-compliance with information governance requirements and standards within the Trust. Underlying issues relate to specific training requirements and the need to enhance the culture of information governance awareness, which has been addressed through the enhanced awareness campaign and specific training.

The Trust was victim of an IT security breach with a serious IT virus affecting its network in August 2015. The virus resulted in the Trust's systems being shut down across all locations. The Trust worked with its IT service provider to rectify the problem and business continuity plans were implemented. Although staff were unable to use electronic systems, there was no reported impact on the service the Trust provides to the people who use its services. There were also no identified information governance breaches as a result of the security breach. The Trust instigated an investigation into the incident and its own response, and a number of areas from which the Trust can learn have been identified. The actions for this will be monitored both by the Executive Management Team and the Information Management and Technology Forum.

Annual Quality Report

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

The following steps have been put in place to assure Trust Board that the Quality Report presents a balanced view and that there are appropriate quality governance arrangements in

place to ensure the quality and accuracy of performance information. Quality metrics are reviewed monthly by Trust Board and the Executive Management Team and form a key part of the performance reviews undertaken by BDU as part of their governance structures. The Clinical Governance and Clinical Safety Committee has delegated authority from Trust Board to oversee the development of and to approve the Quality Report.

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

The Director of Nursing chairs the Trust-wide Improving Clinical Information Group that oversees the Trust's approach to improving the quality of clinical information. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation and that this is supported by appropriate policies or procedures to secure the quality of the data recorded and used for reporting. It is also tasked with ensuring the Trust has in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality. The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

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

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

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

Data use and reporting
Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Delivery EMT and Trust Board, with key performance indicators set at

both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues.

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

Review of effectiveness

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

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

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

The Trust developed a values-based appraisal system for staff in 2013 and has a target for all staff in bands 6 and above to have an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. Although this is challenging, managers and staff work hard to achieve the target within operational capacity achieving 92.3% for bands 6 and above, and 94.7% for the remainder of staff at the year-end. The Trust has also introduced values-based recruitment and selection.

As a result of an inspection visit to the Fieldhead site by the CQC, the Trust was issued with two compliance actions in July 2013. Locations visited were Trinity 2, Newton Lodge and Bretton. The CQC found that overall patients were receiving a good level of service; however, there were some concerns regarding the design and layout of some of the hospital's seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). A detailed action plan was submitted to address the compliance issues, which was fully completed in June 2014. The CQC has yet to confirm that the compliance actions are closed and they are included in this report for completeness.

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

are received by the Board. Further information on Trust Board Committees is contained in the annual report and in the Trust's Risk Management Strategy.

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

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

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team and with the wider Extended Executive Management Team. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

From the internal audit plan for 2015/16, five core internal audit reviews were presented to the Audit Committee. 'Significant assurance' was received for two reports (risk management and board assurance framework, and information governance phase II) and 'significant assurance with minor improvement opportunities' given in two areas (financial management and reporting, and payroll). One report was given 'partial assurance with improvement required' in relation to the phase I review of information governance. The follow up review prior to submission of the Trust's toolkit return resulted in a 'significant assurance' opinion.

For risk-based reviews, three reports received 'significant assurance with minor improvement opportunities' in relation to asset safeguarding and existence, performance indicators and e-rostering. 'Partial assurance with improvement required' was given to four reviews in relation to management of service level agreements, job planning, medicines management and clinical record keeping. There were no reports given a 'no assurance' rating.

One further review in relation to the CQC pre-inspection review and support was advisory and received no rating.

The fieldwork for two remaining reports from the 2015/16 plan relating to support services value for money review (IT services) and agile working/digitisation has been completed and the assurance rating is subject to agreement with management.

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

The Head of Internal Audit's overall opinion for 2015/16 is one of significant assurance with minor improvement opportunities given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the Improving Clinical Information Group and, where data quality standards are identified as a risk factor, these will be reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation. BDUs and the Executive Management Team are also responsible for reviewing and assessing the quality of data and for ensuring mitigating action is in place to ensure any areas of weakness are addressed. Trust Board, through its Committees, also considers data quality from both an operational and analytical perspective. The principles supporting the Trust's approach to data quality are contained in its Data Quality Strategy and Policy.

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

Conclusion

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

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

Over the past year, the Trust has undergone significant change; however, during this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

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Rob Webster
Chief Executive
23 May 2016

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2016

		Group		Trust	
		Year Ended 31 March 2016	Year Ended 31 March 2015	Year Ended 31 March 2016	Year Ended 31 March 2015
	note	£000	£000	£000	£000
Operating Income from continuing operations	5	229,878	237,742	229,837	237,677
Operating Expenses of continuing operations	6	(226,722)	(232,223)	(226,729)	(231,883)
Operating surplus / (deficit)		**3,156**	**5,519**	**3,108**	**5,794**
Finance costs:					
Finance income	10	90	97	89	95
PDC Dividends payable		(2,990)	(2,793)	(2,990)	(2,793)
NET FINANCE COSTS		**(2,900)**	**(2,696)**	**(2,901)**	**(2,698)**
Movement in fair value of investment property and other investments	15	0	16	0	16
SURPLUS/(DEFICIT) FOR THE YEAR		**256**	**2,839**	**207**	**3,112**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments		(30)	0	(30)	0
Revaluations		3,325	2,098	3,325	2,098
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**3,551**	**4,937**	**3,502**	**5,210**

The Group accounts are the consolidation of the Trust (South West Yorkshire Partnership NHS Foundation Trust) and the South West Yorkshire Partnership Foundation Trust and Other Related Charities (see note 1.28 for more details).

The notes numbered 1 to 37 form part of these accounts.

STATEMENT OF FINANCIAL POSITION	note	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Non-current assets					
Intangible assets	13	525	552	525	552
Property, plant and equipment	14	113,460	105,757	113,460	105,757
Investment Property	15	150	340	150	340
Total non-current assets		**114,135**	**106,649**	**114,135**	**106,649**
Current assets					
Inventories	19	190	204	190	204
Trade and other receivables	20	9,862	7,956	9,865	7,978
Non-current assets for sale and assets in disposal groups	16	299	0	299	0
Cash and cash equivalents	21	27,693	33,159	27,107	32,617
Total current assets		**38,044**	**41,319**	**37,461**	**40,799**
Current liabilities					
Trade and other payables	22	(19,287)	(20,578)	(19,272)	(20,577)
Provisions	24	(5,082)	(3,781)	(5,082)	(3,781)
Other liabilities	22	(789)	(751)	(789)	(751)
Total current liabilities		**(25,158)**	**(25,110)**	**(25,143)**	**(25,109)**
Total assets less current liabilities		**127,021**	**122,858**	**126,453**	**122,339**
Non-current liabilities					
Provisions	24	(4,935)	(4,323)	(4,935)	(4,323)
Total assets employed		**122,086**	**118,535**	**121,518**	**118,016**
Financed by					
Taxpayers' equity					
Public Dividend Capital		43,492	43,492	43,492	43,492
Revaluation reserve	26	19,452	16,781	19,452	16,781
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		53,354	52,523	53,354	52,523
Others' equity					
Charitable fund reserves		568	519	0	0
Total taxpayers' and others' equity		**122,086**	**118,535**	**121,518**	**118,016**

The financial statements on pages 2 to 41 were approved by the Board of Directors and authorised for issue on the 23 May 2016 and signed on their behalf by:

Signed…….
Rob Webster Chief Executive Date 23 May 2016

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2016		Group		Trust	
		Year Ended 31 March 2016	Year Ended 31 March 2015	Year Ended 31 March 2016	Year Ended 31 March 2015
	note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		3,156	5,519	3,108	5,794
Operating surplus/(deficit)		**3,156**	**5,519**	**3,108**	**5,794**
Non-cash income and expense:					
Depreciation and amortisation	6	6,565	5,177	6,565	5,177
Impairments	6	364	1,802	364	1,802
Reversal of Impairments	5	(545)	(2,092)	(545)	(2,092)
(Gain)/Loss on Disposal	5 & 6	(2,743)	97	(2,743)	97
(Increase)/Decrease in Trade and Other Receivables	20	869	(1,189)	888	(1,207)
(Increase)/Decrease in Inventories	19	14	78	14	78
Increase/(Decrease) in Trade and Other Payables	22	(1,295)	(627)	(1,295)	(627)
Increase/(Decrease) in Other Liabilities	22	38	(92)	38	(92)
Increase/(Decrease) in Provisions	24	1,913	894	1,913	894
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		14	256	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**8,350**	**9,823**	**8,307**	**9,824**
Cash flows from investing activities					
Interest received	10	89	95	89	95
Purchase of intangible assets	13	(156)	(10)	(156)	(10)
Purchase of Property, Plant and Equipment		(11,118)	(8,148)	(11,118)	(8,148)
Sale of property, plant and equipment and Investment Property		384	401	384	401
NHS Charitable Funds - net cash flows from investing activities		1	2	0	0
Net cash generated from/(used in) investing activities		**(10,800)**	**(7,660)**	**(10,801)**	**(7,662)**
Cash flows from financing activities					
Public dividend capital received		0	95	0	95
PDC Dividend paid		(3,016)	(2,754)	(3,016)	(2,754)
Net cash generated from/(used in) financing activities		**(3,016)**	**(2,659)**	**(3,016)**	**(2,659)**
Increase/(decrease) in cash and cash equivalents		**(5,466)**	**(496)**	**(5,510)**	**(497)**
Cash and Cash equivalents at 1 April		33,159	33,655	32,617	33,114
Cash and Cash equivalents at 31 March		**27,693**	**33,159**	**27,107**	**32,617**

2. Pooled budget

The Group & Trust has no pooled budgets.

3. Operating segments

The Group & Trust has a single operating segment, Healthcare.

4. Income generation activities

The Group & Trust does not undertake any significant income generation activities.

5 OPERATING INCOME	**Group & Trust**	
5.1 Income from activities comprises	**Year Ended 31 March 2016 Total £000**	**Year Ended 31 March 2015 Total £000**
NHS Foundation Trusts	382	362
NHS Trusts	0	0
CCGs and NHS England	193,739	197,073
Local Authorities	16,154	22,611
Department of Health - other	0	0
NHS Other	104	88
Non NHS: Other	2,854	1,093
Total income from activities	**213,233**	**221,227**

	Group & Trust	
5.2 Analysis of income from activities	**Year Ended 31 March 2016 Total £000**	**Year Ended 31 March 2015 Total £000**
Block Contract income - Mental Health Services	155,618	159,708
Income from CCGs & NHS England - Community Services	41,854	45,104
Income not from CCG's, NHS England or PCTs - Community Services	14,832	15,543
Other non-protected clinical income	929	872
Total income from activities	**213,233**	**221,227**

5.3 Other Operating Income	**Note**	**Group Year Ended 31 March 2016 Total £000**	**Group Year Ended 31 March 2015 Total £000**	**Trust Year Ended 31 March 2016 Total £000**	**Trust Year Ended 31 March 2015 Total £000**
Other operating income					
Research and development		113	160	113	160
Education and training		3,169	2,915	3,169	2,915
Other *		7,257	8,037	7,295	8,037
Profit on disposal of land and buildings		2,771	0	2,771	0
Reversal of impairments of property, plant and equipment	12	545	2,092	545	2,092
Income in respect of staff costs where accounted for on a gross basis		2,711	3,246	2,711	3,246
NHS Charitable Funds : Incoming Resources excluding investment income		79	65	0	0
Total other operating income		**16,645**	**16,515**	**16,604**	**16,450**
Total Operating Income		**229,878**	**237,742**	**229,837**	**237,677**

Revenue is mostly from the supply of services. Revenue from the sale of goods and services is not material.

*** Analysis of Other Operating Income: Other**	**Group Year Ended 31 March 2016 Total £000**	**Group Year Ended 31 March 2015 Total £000**	**Trust Year Ended 31 March 2016 Total £000**	**Trust Year Ended 31 March 2015 Total £000**
Estates recharges	572	535	572	535
IT recharges	95	54	95	54
Pharmacy sales	72	272	72	272
Staff contributions to employee benefit schemes	3,043	2,958	3,043	2,958
Catering	214	200	214	200
Property rentals	66	57	66	57
Other	3,195	3,961	3,233	3,961
Total	**7,257**	**8,037**	**7,295**	**8,037**

5.4 Income from activities from Commissioner Requested Services and all other services	**Group Year Ended 31 March 2016 Total £000**	**Group Year Ended 31 March 2015 Total £000**	**Trust Year Ended 31 March 2016 Total £000**	**Trust Year Ended 31 March 2015 Total £000**
Income from Commissioner Requested Services	213,233	221,227	213,233	221,227
Income from non-Commissioner Requested Services	16,645	16,515	16,604	16,450
Total Income	**229,878**	**237,742**	**229,837**	**237,677**

5.5 Operating lease income

The Group & Trust earned no income from operating leases in 2015/16 or in 2014/15.

6 Operating Expenses

6.1 Operating Expenses	Note	Group Year Ended 31 March 2016 £000	Group Year Ended 31 March 2015 £000	Trust Year Ended 31 March 2016 £000	Trust Year Ended 31 March 2015 £000
Services from NHS Foundation Trusts		150	119	137	119
Services from NHS Trusts		40	110	14	110
Services from CCGs and NHS England		132	344	132	344
Purchase of healthcare from non NHS bodies		3,645	4,021	3,845	4,021
Employee Expenses - Executive directors		1,533	1,434	1,533	1,434
Employee Expenses - Non-executive directors		143	131	143	131
Employee Expenses - Staff		169,754	169,778	169,788	169,778
NHS Charitable funds - employee expenses		34	31	0	0
Supplies and services - clinical (excluding drug costs)		3,770	3,725	3,770	3,725
Supplies and services - general		3,759	4,169	3,759	4,169
Establishment		6,349	6,665	6,349	6,665
Transport (Business travel only)		158	177	158	177
Transport (other)		661	766	661	766
Premises - Business rates payable to Local Authorities		624	1,463	624	1,463
Premises - other		9,786	12,319	9,786	12,319
Increase / (decrease) in provision for impairment of receivables	20.2	(15)	(103)	(15)	(103)
Change in provisions discount rate	24	(9)	66	(9)	66
Drug Costs (non inventory drugs only)		988	1,504	988	1,504
Inventories consumed (excluding drugs)	19.1	268	290	268	290
Drug Inventories consumed	19.1	3,121	2,768	3,121	2,768
Rentals under operating leases - minimum lease payments	9.1	6,747	7,026	6,747	7,026
Depreciation on property, plant and equipment	14	6,382	4,946	6,382	4,946
Amortisation on intangible assets	13	183	231	183	231
Impairments of property, plant and equipment	12	364	1,802	364	1,802
Audit services- statutory audit		62	65	62	65
Audit services - charitable fund accounts		1	2	0	0
Other auditor remuneration	6.2	71	30	71	30
Clinical negligence - amounts payable to the NHSLA (premiums)		290	275	290	275
Loss on disposal of land and buildings		28	97	28	97
Legal fees		174	147	174	147
Consultancy costs		1,513	1,741	1,552	1,741
Internal audit costs		97	123	97	123
Training, courses and conferences		774	738	774	738
Patient travel		26	30	26	30
Car parking & Security		4	6	4	6
Redundancy	7.1	3,123	3,028	3,123	3,028
Early retirements		31	44	31	44
Hospitality		87	74	87	74
Publishing		49	67	49	67
Insurance		260	311	260	311
Other services, eg external payroll		14	0	14	0
Losses, ex gratia & special payments		505	4	505	4
Other		816	1,475	854	1,352
NHS Charitable funds: Other resources expended		230	184	0	0
Total Operating Expenses		**226,722**	**232,223**	**226,729**	**231,883**

The 2014/15 numbers have been re-stated to identify internal audit costs in line with guidance within the 2015/16 FT ARM. The overall total is unchanged.

10. Finance Income	Group Year Ended 31 March 2016 £000	Group Year Ended 31 March 2015 £000	Trust Year Ended 31 March 2016 £000	Trust Year Ended 31 March 2015 £000
Interest on loans and receivables	89	95	89	95
NHS Charitable funds: investment income	1	2	0	0
Total	**90**	**97**	**89**	**95**

The Group & Trust has no interest on impaired financial assets included in finance income in 2015/16 or in 2014/15.

11. Finance Costs - interest expense

The Group & Trust incurred no finance costs in 2015/16 or in 2014/15.

12. Impairment of assets (Property, Plant, and Equipment & intangibles)

	Group & Trust					
	31 March 2016			31 March 2015		
	Net Impairment £000	Impairments £000	Reversals £000	Net Impairment £000	Impairments £000	Reversals £000
Impairments charged to operating surplus / deficit:						
Other	**0**	0	0	**0**	0	0
Changes in market price	(181)	364	(545)	(290)	1,802	(2,092)
Total Impairments charged to operating surplus / deficit	**(181)**	**364**	**(545)**	**(290)**	**1,802**	**(2,092)**
Impairments charged to the revaluation reserve	30	30	0	0	0	0
Total Impairments	**(151)**	**394**	**(545)**	**(290)**	**1,802**	**(2,092)**

In 2015/16 the Trust undertook a desktop revaluation of the Estate, resulting in a net benefit of £181k.

13 Intangible assets

13.1 Intangible assets 2015/16	Group & Trust	
	Total	Software licences (purchased)
	£000	£000
Gross cost at 1st April 2015	**1,833**	1,833
Additions - purchased	**156**	156
Gross Cost at 31 March 2016	**1,989**	**1,989**
Amortisation at 1st April 2015	**1,281**	1,281
Provided during the year	**183**	183
Amortisation at 31 March 2016	**1,464**	**1,464**
Net book value		
NBV - Purchased at 31 March 2016	**525**	525
NBV total at 31 March 2016	**525**	**525**

13.2 Intangible assets 2014/15	Group & Trust	
	Total	Software licences (purchased)
	£000	£000
Gross cost at 1st April 2014	**1,823**	1,823
Additions - purchased	**10**	10
Gross Cost at 31 March 2015	**1,833**	**1,833**
Amortisation at 1st April 2014	**1,050**	1,050
Provided during the year	**231**	231
Amortisation at 31 March 2015	**1,281**	**1,281**
Net book value		
NBV - Purchased at 31 March 2015	**552**	552
NBV total at 31 March 2015	**552**	**552**

13.3 Intangible assets

Intangible Assets are all purchased software licences and are depreciated over the life of the licence which is currently no more than 5 years. There has been no revaluation of these assets.
No Intangible Assets were acquired by Government Grant.

14.1 Property, plant and equipment 31 March 2016

Group & Trust	Total	Land	Buildings excluding dwellings	Assets under Construction & Payments On Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2015	**117,663**	18,427	87,087	1,936	5,069	861	2,753	1,530
Additions - purchased	**11,133**	0	1,863	7,220	51	0	1,693	306
Impairments charged to the revaluation reserve (note 12)	**(30)**	(30)	0	0	0	0	0	0
Reclassifications	**0**	0	6,675	(6,675)	0	0	0	0
Revaluations	**473**	0	473	0	0	0	0	0
Reclassified as held for sale	**(300)**	(130)	(170)	0	0	0	0	0
Disposals	**(305)**	(98)	(121)	0	(47)	(39)	0	0
Cost or Valuation at 31 March 2016	**128,634**	**18,169**	**95,807**	**2,481**	**5,073**	**822**	**4,446**	**1,836**
Accumulated depreciation at 1st April 2015	**11,906**	(0)	5,572	0	3,052	625	2,066	591
Provided during the year	**6,382**	0	5,503	0	362	76	305	136
Impairments charged to operating expenses(note 12)	**364**	70	294	0	0	0	0	0
Reversal of impairments credited to operating income (note 12)	**(545)**	0	(545)	0	0	0	0	0
Revaluations	**(2,852)**	0	(2,852)	0	0	0	0	0
Reclassified as held for sale	**(1)**	0	(1)	0	0	0	0	0
Disposals	**(80)**	0	(9)	0	(47)	(24)	0	0
Accumulated depreciation at 31 March 2016	**15,174**	**70**	**7,962**	**0**	**3,367**	**677**	**2,371**	**727**
Net book value								
Net book value at 31 March 2016								
NBV - Owned at 31 March 2016	**113,460**	18,099	87,845	2,481	1,706	145	2,075	1,109
NBV - Donated at 31 March 2016	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2016	**113,460**	**18,099**	**87,845**	**2,481**	**1,706**	**145**	**2,075**	**1,109**

Accumulated depreciation on land relates to historic impairments recognised through operating expenditure.

Included within buildings are improvements to buildings which are not owned by the Trust (Leasehold). These assets are not revalued in the year and hence not all accumulated depreciation has been reversed out upon revaluation.

14.2 Property, plant and equipment 31 March 2015

Group & Trust	Total	Land	Buildings excluding dwellings	Assets under Construction & Payments On Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2014	**112,557**	18,569	81,630	2,337	5,065	861	2,624	1,471
Additions - purchased	**6,120**	0	3,747	1,858	305	0	129	81
Reclassifications	**0**	0	2,259	(2,259)	0	0	0	0
Revaluations	**(351)**	3	(354)	0	0	0	0	0
Disposals	**(663)**	(145)	(195)	0	(301)	0	0	(22)
Cost or Valuation at 31 March 2015	**117,663**	**18,427**	**87,087**	**1,936**	**5,069**	**861**	**2,753**	**1,530**
Accumulated depreciation at 1st April 2014	**9,949**	85	4,207	0	2,886	537	1,761	473
Provided during the year	**4,946**	0	4,019	0	398	88	305	136
Impairments charged to operating expenses (note 12)	**1,802**	0	1,802	0	0	0	0	0
Reversal of impairments credited to operating income (note 12)	**(2,092)**	0	(2,092)	0	0	0	0	0
Revaluations	**(2,449)**	(85)	(2,364)	0	0	0	0	0
Disposals	**(250)**	0	0	0	(232)	0	0	(18)
Accumulated depreciation at 31 March 2015	**11,906**	**(0)**	**5,572**	**0**	**3,052**	**625**	**2,066**	**591**
Net book value								
Net book value at 31 March 2015								
NBV - Owned at 31 March 2015	**105,757**	18,427	81,515	1,936	2,017	236	687	939
NBV - Donated at 31 March 2015	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2015	**105,757**	**18,427**	**81,515**	**1,936**	**2,017**	**236**	**687**	**939**

Accumulated depreciation on land relates to historic impairments recognised through operating expenditure.

Included within buildings are improvements to buildings which are not owned by the Trust (Leasehold). These assets are not revalued in the year and hence not all accumulated depreciation has been reversed out upon revaluation.

14.3 Economic Lives of Property, Plant and Equipment

	Group & Trust	
	Min Life Years	Max Life Years
Land	0	0
Buildings excluding dwellings	0	90
Dwellings	0	0
Plant & Machinery	0	10
Transport Equipment	0	6
Information Technology	0	5
Furniture & Fittings	0	10

14.4 Finance Leases

The Group & Trust hold no finance lease assets.

15 Investments

15.1 Investments - Carrying Value

	Group & Trust	
	Property*	Property*
	31 March 2016	31 March 2015
	£000	£000
At Carrying Value		
Balance at Beginning of Period	340	410
Fair value gains (taken to I&E)	0	16
Disposals	(190)	(86)
Balance at End of Period	**150**	**340**

* The Group & Trust has no other investments.

Estate which the Trust Board has declared surplus to requirements is recorded as investment property under IFRS and its value is updated annually to the current market value as part of the wider estate revaluation.

15.2 Investment Property expenses

The Group & Trust incurred £2k on investment property expenses in 2015/16 (£30k in 2014/15). These related to the potential sale of the properties.

15.3 Investments in subsidiaries

The Trust is the Corporate Trustee for the NHS Charity, South West Yorkshire Partnership Foundation Trust and Other Related Charities, registered charity number 1055931. The Charity operates for the benefit of the Service Users of the Trust.

The registered office is Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.

The following are summary statements before group eliminations which have been consolidated into these accounts in 2015/16.

Summary Statement of Financial Activities

	31 March 2016	31 March 2015
	£000	£000
Total Incoming Resources	318	67
Staff Costs	(34)	(31)
Resources expended with bodies outside the NHS	(235)	(309)
Net movement in funds	**49**	**(273)**

Summary Statement of Financial Position	31 March 2016	31 March 2015
	£000	£000
Cash and cash equivalents	586	542
Trade and other receivables	0	0
Trade and other payables	(18)	(23)
Net Assets	**568**	**519**
Other restricted income funds	338	0
Unrestricted income funds	230	519
Total Charitable Funds	**568**	**519**

16. Non-current assets held for sale and assets in disposal groups

16.1 Non-current assets held for sale

	Group & Trust		
	Total	**PPE: Land**	**PPE: Buildings**
	£000	**£000**	**£000**
NBV of non-current assets for sale at 1 April 2015	**0**	**0**	**0**
Plus assets classified as available for sale in the year	299	130	169
Less assets sold in year	0	0	0
NBV of non-current assets for sale at 31 March 2016	**299**	**130**	**169**

The asset relates to one property which has been sold subject to contract and is expected to complete in Q1 2016/17.
The Group & Trust has no non-current assets held for sale in 2014/15.

16.2 Liabilities in disposal groups

The Group & Trust has no liabilities in disposal groups in 2015/16 or in 2014/15.

17. Other assets

The Group & Trust has no other assets in 2015/16 or in 2014/15.

18. Other Financial Assets

The Group & Trust has no other financial assets in 2015/16 or in 2014/15.

19. Inventories

19.1. Inventory Movements

	Group & Trust		
	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2015	**204**	**71**	**133**
Additions	3,375	3,119	256
Inventories recognised in expenses	(3,389)	(3,121)	(268)
Carrying Value at 31 March 2016	**190**	**69**	**121**

	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2014	**282**	**60**	**222**
Additions	2,980	2,779	201
Inventories recognised in expenses	(3,058)	(2,768)	(290)
Carrying Value at 31 March 2015	**204**	**71**	**133**

Under the Trust accounting policies, inventory is valued at the lower of cost and net realisable value on a first in first out basis.
Other Inventories is stock held at the Community Equipment Stores (Loans Service) in Barnsley.

20. Trade and other receivables

20.1 Trade and other receivables	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Current				
NHS Receivables	2,623	3,015	2,623	3,015
Receivables due from NHS charities – Revenue	0	0	3	22
Other receivables with related parties	1,368	1,031	1,368	1,031
Provision for impaired receivables	(92)	(107)	(92)	(107)
Prepayments	892	1,009	892	1,009
Accrued income	1,332	2,357	1,332	2,357
VAT receivable	302	167	302	167
Other receivables - revenue	662	484	662	484
Other receivables - capital	2,775	0	2,775	0
NHS Charitable funds: Trade and other receivables	0	0	0	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**9,862**	**7,956**	**9,865**	**7,978**

The Group & Trust have no non current trade and other receivables as at 31 March 2016 (£0 (zero) as at 31 March 2015).

20.2 Provision for impairment of receivables	Group & Trust 31 March 2016 £000	Group & Trust 31 March 2015 £000
Balance at start of period	107	277
Increase in provision	65	81
Amounts utilised	0	(67)
Unused amounts reversed	(80)	(184)
Balance at 31 March	**92**	**107**

The Trust assess financial assets (Non NHS debtors including salary overpayments) beyond their due date and, as appropriate, provide for these through the use of the bad debt provision.

20.3 Analysis of impaired receivables	Group & Trust 31 March 2016 £000	Group & Trust 31 March 2015 £000
Ageing of impaired receivables		
0 - 30 days	17	5
30-60 Days	1	2
60-90 days	8	0
90- 180 days	20	13
over 180 days	46	87
Total	**92**	**107**

Ageing of non-impaired receivables past their due date	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
0 - 30 days	1,840	1,866	1,840	1,941
30-60 Days	221	60	221	60
60-90 days	195	82	195	82
90- 180 days	103	255	103	255
over 180 days	70	907	70	907
Total	**2,429**	**3,170**	**2,429**	**3,245**

20.4 Finance lease receivables

The Group & Trust has no finance lease receivables.

21. Cash and cash equivalents	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Balance at 1st April	**33,159**	**33,655**	**32,617**	**33,114**
Net change in year	(5,467)	(496)	(5,510)	(497)
Balance at 31 March	**27,693**	**33,159**	**27,107**	**32,617**
Broken down into:				
Cash at commercial banks and in hand	699	632	113	90
Cash with the Government Banking Service	26,994	32,527	26,994	32,527
Cash and cash equivalents as in statement of financial position	**27,693**	**33,159**	**27,107**	**32,617**
Cash and cash equivalents as in statement of cash flows	**27,693**	**33,159**	**27,107**	**32,617**

Third party assets (Patient Monies) held by the Trust

	Group & Trust 31 March 2016 £000	Group & Trust 31 March 2015 £000
Bank balances	213	233
Monies on deposit	79	74
Total third party assets	**292**	**307**

Third party assets have been excluded from the cash and cash equivalents figure reported in the accounts.

22. Trade and other payables

22.1 Trade and other payables	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Current				
NHS payables - capital	87	0	87	0
NHS payables - revenue	1,054	993	1,054	993
Amounts due to other related parties - revenue	2,625	2,787	2,625	2,787
Other trade payables - capital	698	770	698	770
Other trade payables - revenue	2,751	2,073	2,751	2,073
Social Security costs	1,894	1,879	1,894	1,879
Other taxes payable	1,480	1,522	1,480	1,522
Other payables	87	171	87	171
Accruals	8,576	10,336	8,576	10,336
PDC dividend payable	20	46	20	46
NHS Charitable funds: Trade and other payables	15	1	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**19,287**	**20,578**	**19,272**	**20,577**

The Group & Trust had no non current trade and other payables as at 31 March 2016 (£0 (zero) as at 31 March 2015).

22.2 Better Payment Practice Code

	Group & Trust	
Better Payment Practice Code - measure of compliance	**31 March 2016 Number**	**31 March 2016 £000**
Total Non-NHS trade invoices paid in the year	37,378	61,027
Total Non NHS trade invoices paid within target	35,842	56,473
Percentage of Non-NHS trade invoices paid within target	**96%**	**93%**
Total NHS trade invoices paid in the year	760	11,898
Total NHS trade invoices paid within target	697	10,614
Percentage of NHS trade invoices paid within target	**92%**	**89%**
	31 March 2015 Number	**31 March 2015 £000**
Total Non-NHS trade invoices paid in the year	40,483	52,587
Total Non NHS trade invoices paid within target	37,390	46,060
Percentage of Non-NHS trade invoices paid within target	**92%**	**88%**
Total NHS trade invoices paid in the year	939	15,728
Total NHS trade invoices paid within target	810	13,899
Percentage of NHS trade invoices paid within target	**86%**	**88%**

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

22.3 Early retirements detail included in NHS payables

The Group & Trust had no early retirement costs included in payables as at 31 March 2016 (£0 (zero) as at 31 March 2015).

22.4 Other liabilities

	Group & Trust	
	31 March 2016 £000	**31 March 2015 £000**
Current		
Deferred Income	789	751
TOTAL OTHER CURRENT LIABILITIES	**789**	**751**
Non-current		
Deferred Income	0	0
TOTAL OTHER NON CURRENT LIABILITIES	**0**	**0**

22.5 Other Financial Liabilities

The Group & Trust had no other financial liabilities as at 31 March 2016 (£0 (zero) as at 31 March 2015).

23. Borrowings

The Group & Trust had no borrowings as at 31 March 2016 (£0 (zero) as at 31 March 2015).

24. Provisions

	Group & Trust Current		Group & Trust Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Pensions relating to other staff	58	58	558	589
Legal claims	88	93	1,048	916
Equal Pay	0	6	0	0
Redundancy	4,880	3,235	1,940	1,940
Other				
Injury Benefit	56	55	1,389	878
Other	0	334	0	0
Total	**5,082**	**3,781**	**4,935**	**4,323**

	Group & Trust					
	Total	Pensions relating to other staff	Legal claims	Equal Pay	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2015	8,104	647	1,009	6	5,175	1,267
Change in the discount rate	(9)	(3)	0	0	0	(6)
Arising during the year	5,538	31	242	0	4,690	575
Utilised during the year (accruals)	(29)	(15)	0	0	0	(14)
Utilised during the year (cash)	(1,687)	(44)	(115)	0	(1,477)	(51)
Reversed unused	(1,900)	0	0	(6)	(1,568)	(326)
At 31 March 2016	**10,017**	**616**	**1,136**	**0**	**6,820**	**1,445**
Expected timing of cash flows:						
Not later than one year;	5,082	58	88	0	4,880	56
Later than one year and not later than five years	3,934	225	1,048	0	1,940	721
Later than five years (see note 30.3).	1,001	333	0	0	0	668
Total	**10,017**	**616**	**1,136**	**0**	**6,820**	**1,445**

Pensions relating to former directors and staff - these provisions relate to the expected pension payments to former employees. The total value is based upon a standard life expectancy of the former employee. Should this life expectancy be different the value and timing of the payments will be affected. The value of the pension payment is also affected by annual pension increases, determined by the NHS Pensions Agency.

Redundancy - This provision, totalling £6.8m, relates to approximately 142 posts during 2016 / 2017 and a further 51 redundancies during 2017 / 2018. These are estimates based upon the Trust Annual Plan and Cost Improvement Programme.

Legal claims - these provisions relate to public and employer's liability claims. The value and timing of the payments is uncertain until the claims have been fully investigated and any settlements agreed.

Equal pay - this relates to provisions for 6 equal pay claims. The provision is for legal costs only. As per NHS guidance the Trust is not presently making a provision in terms of settlement of the claims. These claims have been resolved and the provision reversed in 2015/16.

Other - injury benefits are payable by the NHS Pensions Agency. The total value of the provision is based upon a standard life expectancy of the former employee. Should this life expectancy not be achieved the value and timing of the payments will be affected. The value of the pension payment is also affected by annual pension increases, determined by the NHS Pensions Agency.

Other - There is a £500k provision in relation to a potential fine relating to Information Governance breaches

£2,943K is included in the provisions of the NHS Litigation Authority at 31 March 2016 (£739k at 31 March 2015) in respect of clinical negligence liabilities of the NHS Trust.

25. Contingencies

25.1 Contingent liabilities

The Group & Trust had no contingent liabilities as at 31 March 2016 (none as at 31 March 2015).

25.2 Contingent assets

The Group & Trust had 1 contingent asset as at 31 March 2016 (1 as at 31 March 2015).

The Group & Trust contingent asset relates to the expected sale of non Trust estate for which the Trust is entitled to a proportion of the land receipt.

26. Revaluation reserve

	Group & Trust	
	Total Revaluation Reserve	**Revaluation Reserve - property, plant and equipment**
	£000	**£000**
As at 1 April 2015	**16,781**	**16,781**
Impairments	(30)	(30)
Revaluations	3,325	3,325
Transfers to other reserves	(532)	(532)
Asset disposals	(92)	(92)
Revaluation reserve at 31 March 2016	**19,452**	**19,452**

	£000	**£000**
As at 1 April 2014	**14,785**	**14,785**
Impairments	2,098	2,098
Other reserve movements	(102)	(102)
Revaluation reserve at 31 March 2015	**16,781**	**16,781**

The transfers to other reserves relate to revaluation balances for assets that were disposed of in year and have been transferred to the Income and Expenditure reserve.

27. Finance lease obligations

The Group & Trust had no finance lease obligations.

28. Finance lease commitments

The Group & Trust had not entered into any new finance leases during the year.

29. Capital commitments

Contracted capital commitments at the year end not otherwise included in these financial statements:

	Group & Trust	
	31 March 2016	**31 March 2015**
	£000	**£000**
Property, plant and equipment	1,787	4,831
Intangible assets	0	0
Total	**1,787**	**4,831**

These capital commitments relate to on-going developments for a Pontefract Hub with the main Trust Contractor.

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

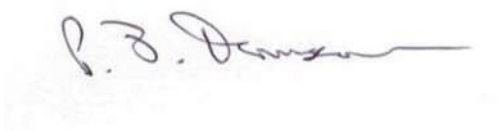
18 May 2016

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 Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	G [Subject to correction]
Consistency 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 [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 Is data recorded correctly and is it in line with the methodology.	G	B	R
Validity Has the data been produced in compliance with relevant requirements.	G	G	n\a
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	G	R
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	G	G	R
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	R
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	G	G	R
Recommendations identified?	×	✓	✓
Overall Conclusion	G Unmodified Opinion	B 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

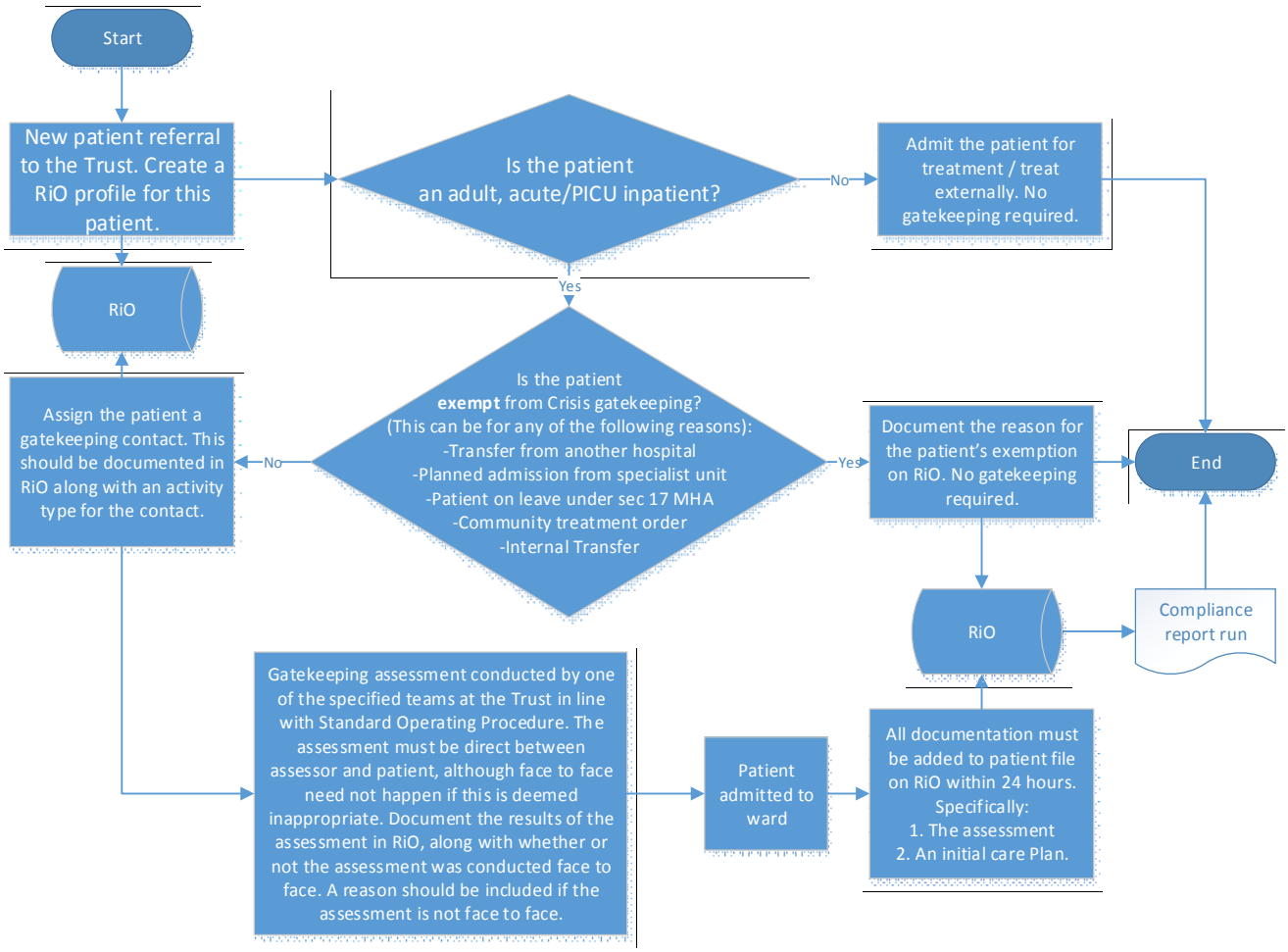
We found that the indicator was not materially mistated

	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.

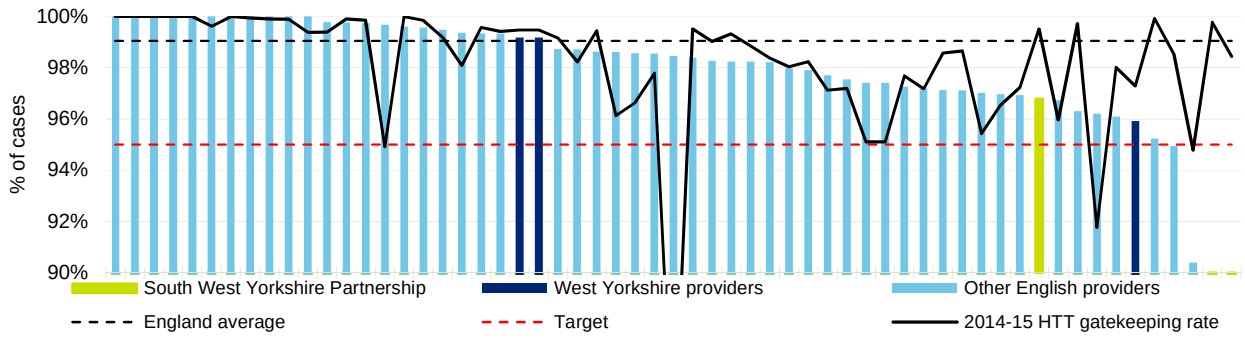


Access to crisis resolution home treatment team (continued)

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

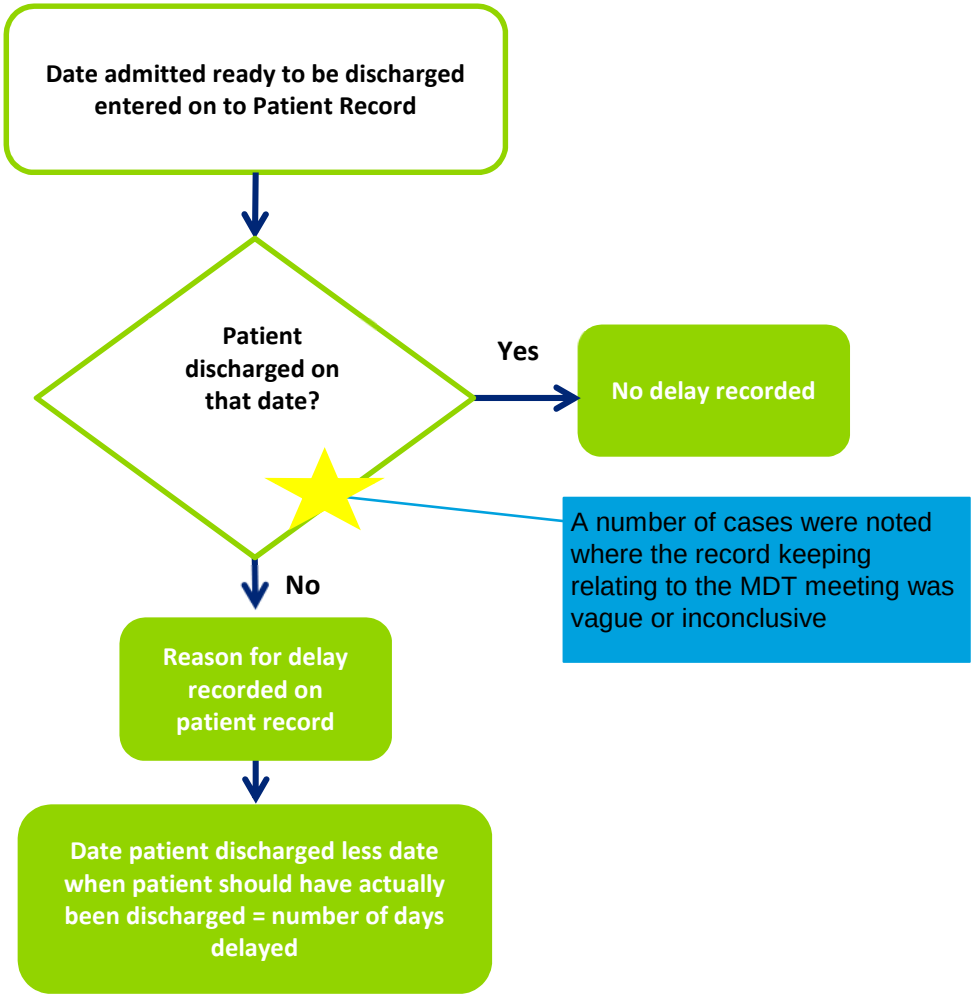
Definition: "The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

[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 Medium Priority	**Date recording in patient notes** 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 Steps should be taken to eliminate the risk of self review and bias in the selecting and auditing of cases. Key improvements required include: • Audits to be completed by a member of staff independent of the reporting clinical team; • Samples to be selected independently of the reporting clinical team; • Sample sizes should be set at 10 items per area and returns either below or in excess of 10 items should be challenged; and • Returns should be gathered from all teams and nil returns challenged.	
Care Plan within 28 days. Medium Priority	**Maintenance of audit trail** 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**: **Timeline**:
	Timeliness of performance reporting The data upon which performance was to be reported was almost 12 months old, management should either: • alter the timing of the evaluation exercise to ensure that the performance being reported is up to date, or • make the age of the reported performance clear in public reporting.	**Responsible Officer**: **Timeline**:
	Clarity of decision making 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**: **Timeline**:

Update on prior year recommendations

Our prior year recommendations have been updated.

	Deloitte Recommendation	Management provided update
7 day follow up	**Contact date** 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** Improvements should be made in recording of date ready for discharge / commencement of delay to discharge.	
Waterlow assessment	**Timing of assessment** 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

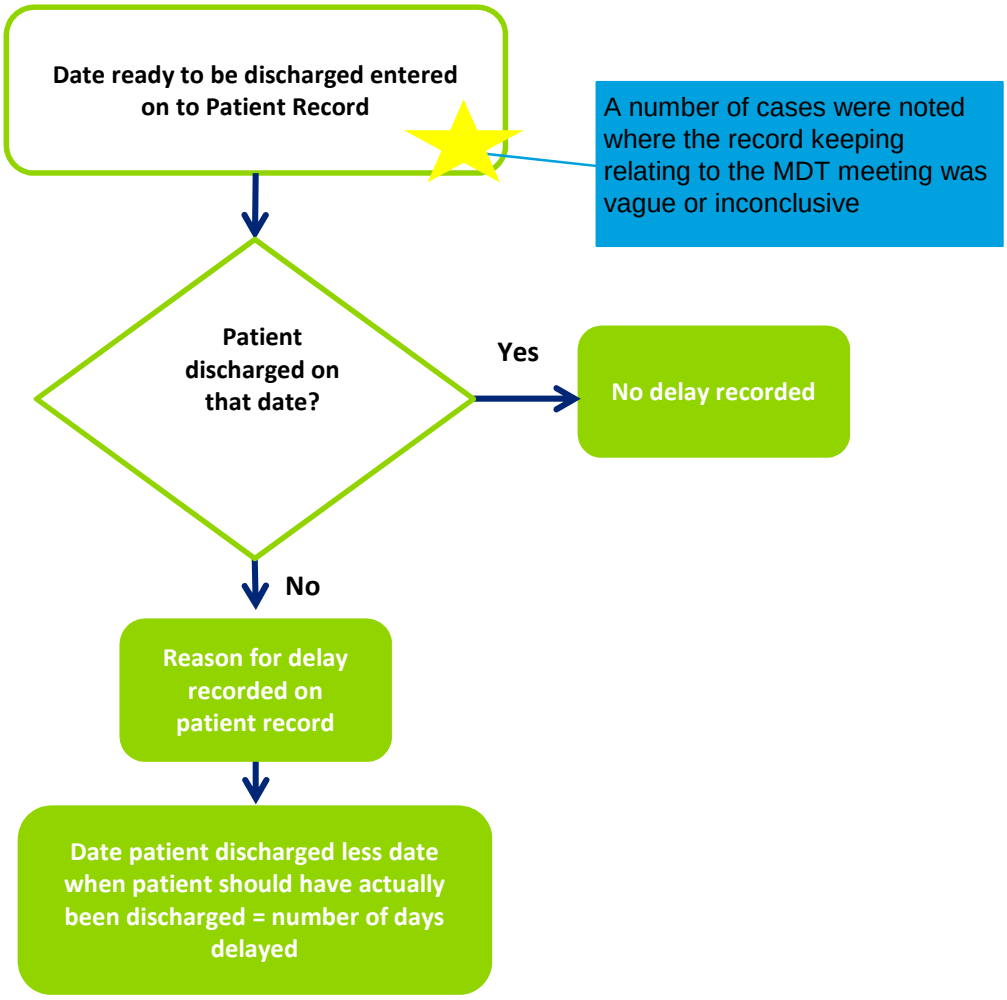
Definition: "The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

[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:

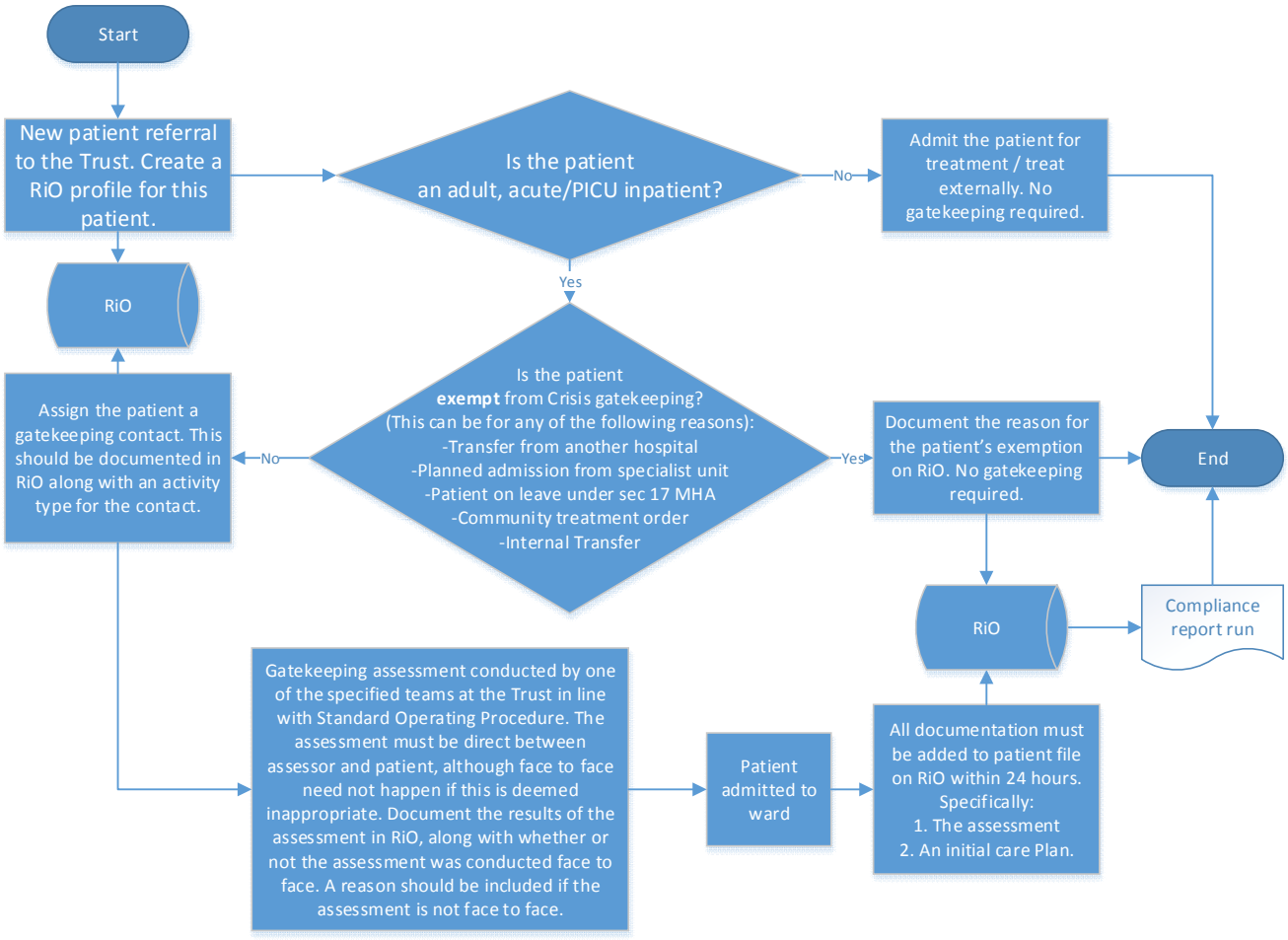
In 4 of the cases sampled we noted that there was lack of evidence regarding the precise date on which the delay began. Whilst this is an improvement on our 2014/15 findings when we detected 9 items where there was insufficient evidence, it remains the case that there is scope for improvement to the 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** 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. June 2016
Local indicator- care plan within 28 days			
1.	**Validity of Methodology** Steps should be taken to eliminate the risk of self- review and bias in the selecting and auditing of cases. Key improvements required include: • Audits to be completed by a member of staff independent of the reporting clinical team; • Samples to be selected independently of the reporting clinical team; • Sample sizes should be set at 10 items per area and returns either below or in excess of 10 items should be challenged; and • 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. We will update our clinical record keeping audit guidance to ensure teams are clear of the methodology.	Assistant Director of Nursing, Professions and Governance. June 2016
2.	**Maintenance of audit trail** Management should take steps to ensure that the audit trail	We acknowledge that this is correct and	Assistant Director of

	from 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. Complete April 2016
3.	**Timeliness of performance reporting** The data upon which performance was to be reported was almost 12 months old, management should either: • alter the timing of the evaluation exercise to ensure that the performance being reported is up to date, or • 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. 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. Complete May 2016
4.	**Clarity of decision making** 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. June 2016

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Independent auditor's report to the council of governors of South West Yorkshire Partnership NHS Foundation Trust on the quality report

We have been engaged by the council of governors of South West Yorkshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of South West Yorkshire Partnership NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of South West Yorkshire Partnership NHS Foundation Trust as a body, to assist the council of governors in reporting South West Yorkshire Partnership NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South West Yorkshire Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Delayed transfers of care (page 31-32); and
- Admissions to inpatient services had access to Crisis Resolution/Home Treatment Teams (page 32)

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

Independent auditor's report to the council of governors of South West Yorkshire Partnership NHS Foundation Trust on the quality report (continued)

We read the quality report and consider whether it addresses the content requirements of the '*NHS Foundation Trust annual reporting manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- Board minutes for the period April 2015 to April 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from Commissioners, dated 20 May 2016 and 25 May 2016;
- feedback from Calderdale and Huddersfield NHS Foundation Trust dated 20 May 2016
- feedback from Healthwatch Wakefield, (undated);
- feedback from the Wakefield Overview and Scrutiny Committee, (undated);
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30 June 2015 and the quarterly complaints reports covering the year 2015/16;
- the 2015 Patient Survey Report;
- the 2015 national staff survey;
- Care Quality Commission Intelligent Monitoring Report dated November 2014; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS Foundation Trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Independent auditor's report to the council of governors of South West Yorkshire Partnership NHS Foundation Trust on the quality report (continued)

Conclusion

Based on the results of our procedures, 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 'NHS Foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust annual reporting manual'.

Deloitte LLP

Chartered Accountants

Leeds, UK

26 May 2016

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
22 July 2016

Agenda item:	**9**
Report Title:	Implementation of the upgrade to the Trust's clinical information system (RiO)
Report By:	Dawn Stephenson/Mark Brooks
Job Title:	Director of Corporate Development/Director of Finance
Action:	To receive

EXECUTIVE SUMMARY

Purpose and format

The purpose of this report is to update the Members' Council on the external review of the implementation of the upgrade to the Trust's clinical information system, RiO.

Recommendation

The Members' Council is asked to RECEIVE the report.

Introduction

The Members' Council received a presentation at its last meeting, which provided the background to the issues arising from the implementation of the upgrade to V7 of the Trust's clinical information system, RiO. This is included in the papers as a reminder to inform this paper.

Deloitte was commissioned to conduct a review of the RiO 7 implementation and identify any learning points for the Trust. This review has been considered and reviewed by both the Executive Management Team (EMT) and the Trust Board Information Management and Technology Forum.

Outcome of the review

The key themes arising from the review were as follows.

- In terms of the IT environment, WES updates were not clearly and consistently communicated.
- Technical complexity and resource capacity were not presented in sufficient detail or subject to sufficient scrutiny.
- Execution of the implementation and 'go-live' lacked a sufficiently robust readiness framework.
- Project arrangements and issue management did not adequately bring together the senior leaders of the Trust and Servelec.

A number of recommendations were made by Deloitte with advice on prioritisation, which the Trust has accepted. A number of recommendations have already been acted upon with the remainder planned. Progress will be monitored through the EMT and at Board-level through the Information Management and Technology Forum.

Next steps

The most important next step is to address outstanding system performance issues. A deadline for the end of July 2016 has been agreed with the Information Management and Technology Forum. By this time, the Trust will be able to determine the effectiveness of the fixes made and actions taken to address the outstanding issues. This will enable a further decision to be made regarding any changes to how the system is used or technical solutions. The Trust will ensure there is ample clinical engagement in the process between now and the end of July so that decisions can be taken in line with the recommendations made in the Deloitte report.

A full review of existing IT projects is taking place to identify where processes and arrangements need to be strengthened in light of the recommendations made. For all future projects a checklist will be made of all requirements, including those identified in the Deloitte report, to ensure that a full and comprehensive consideration of all requirements is made in advance of the project going live.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
6 May 2016

Trust Clinical Information System (RiO) v7
Upgrade Position Statement

With all of us in mind

RiO version 7 upgrade

- Upgrade of RiO v6 took place on 20 November 2015
- Following the upgrade there were system performance and functionality issues
- Access to the system was slow and users reported system functionality not performing as intended
- STEIS incident reported to commissioners

Impact to services

- Unreliable access to the system
- Clinical risk due to loss of data caused by unexpected user session time out and system not saving data
- Backlog of work requiring input
- Difficulty accessing clinical records stored in the system
- Loss of confidence in the system by staff

Follow on actions

- Director level meetings with the supplier (Servelec) have taken place (in February and April 2016)
- Daily conference calls to review issues and progress (internal & external with Servelec)
- Communication updates via TRIO network and emails to all staff
- Technical investigations for root cause analysis
- Additional training and support for staff ongoing

Outstanding issues

- Outstanding issues are being regularly reviewed with Servelec for problem resolution
- Key issue under investigation is random disconnection and error messages being received by users resulting in lost data and subsequent clinical risk

Ongoing remedial work

- Servelec is working to deliver a number of system changes where functionality is not working as intended
- Servelec engineers have been reviewing all issues logged to ensure optimal system performance

Next steps

- Ongoing Director level meetings with Servelec to review progress
- Independent review of the RiO upgrade process commissioned by Director of Corporate Development from Deloitte

South West Yorkshire Partnership NHS
NHS Foundation Trust

Members' Council
22 July 2016

Agenda item:	**10**
Report Title:	Customer services and incident management annual reports
Report By:	Dawn Stephenson/Tim Breedon
Job Title:	Director of Corporate Development/Director of Nursing and Professions, Clinical Governance and Safety
Action:	This item is for information and will be considered in detail by the Members' Council Quality Group on 30 August 2016

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to provide the Members' Council with the customer services and incident management annual reports for information. Both reports have been considered and scrutinised by Trust Board and the Clinical Governance and Clinical Safety Committee. Both reports will be considered and discussed in more detail by the Members' Council Quality Group at its next meeting on 30 August 2016.

Recommendation

The Members' Council is asked to RECEIVE the reports, which will be discussed in more detail at the Members' Council Quality Group on 30 August 2016.

Customer services annual report 2015/16 – summary

The report covers the financial year 2015/16 and provides an overview of issues raised through Customer Services during this period. The Trust aims to improve the experience of people who use services by responding positively to feedback and resolving issues as they happen whenever possible and at every level in the organisation.

During the period covered by the report:

- 342 formal complaints were investigated, with learning shared as appropriate;
- seventeen cases (5%) were raised with the Parliamentary and Health Service Ombudsman with two upheld and one partially upheld in the period;
- 351 informal concerns, 579 enquiries and 124 comments were made;
- 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 ongoing to encourage all services to share compliments received;
- 265 requests for information under Freedom of Information Act were processed.

The Customer Services 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.

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 re-design) and Forensic services (not automatically viewed as a service of choice).

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.

Incident management annual report 2015/16 – 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 (National Patient Safety Agency Seven Steps to Safety).

Although the number of incidents reported across the Trust has increased, the overall proportion of more serious incidents forms a lower proportion of all incidents than last year. The number of apparent suicides has decreased from last year from 45 to 41.

During 2015/16, there were no 'never events', no homicides and the Trust has not been issued any Section 28 letters by the Coroner.

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".

The Trust continues to focus on learning lessons from incidents and is rated as 'good' in this area when benchmarked against Trusts nationally.

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. This is reported to Trust Board on a quarterly basis.

The Trust continues to implement its Patient Safety Strategy, including the 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.

Next steps

- 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.
- 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.
- To review of policies relating to the Trust's serious incident framework.
- To use feedback from users to improve the Datixweb experience for users.
- To network with other Trusts across West Yorkshire.

It is intended that 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. These reports will be available to the Members' Council as part of the Trust Board papers.

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:

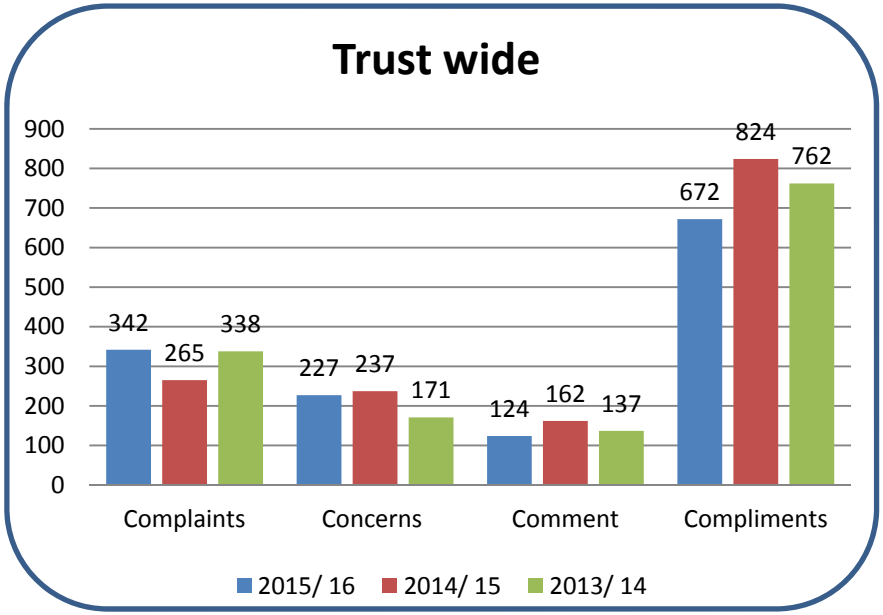
- the number of issues raised and the themes arising, and Friends and Family Test results
- equality data
- external scrutiny and partnering
- Customer Services standards including response timeframes
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received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

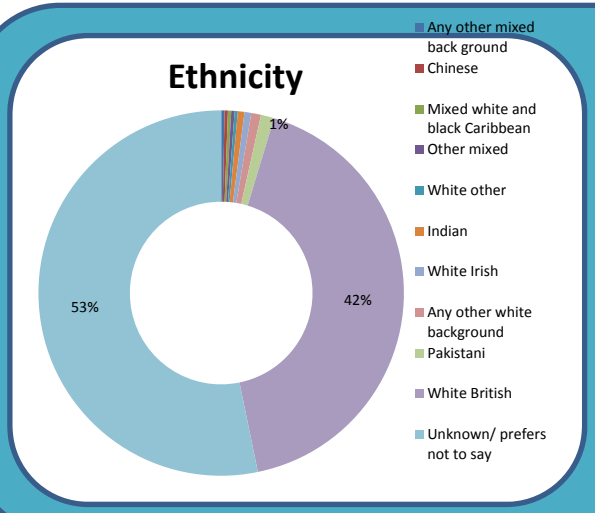
National guidance emphasises the importance of organisations working together where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

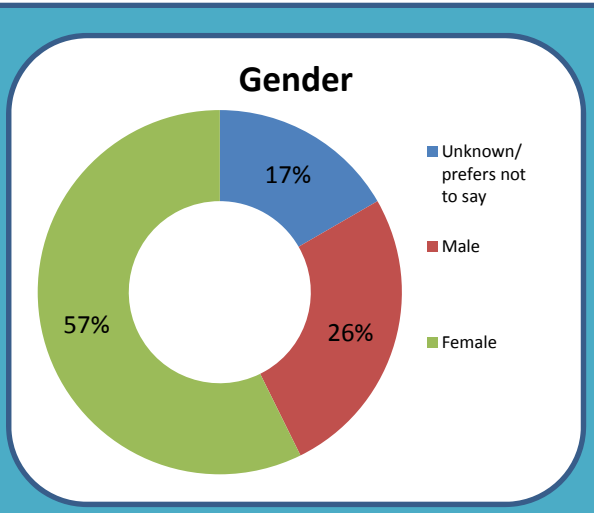
Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

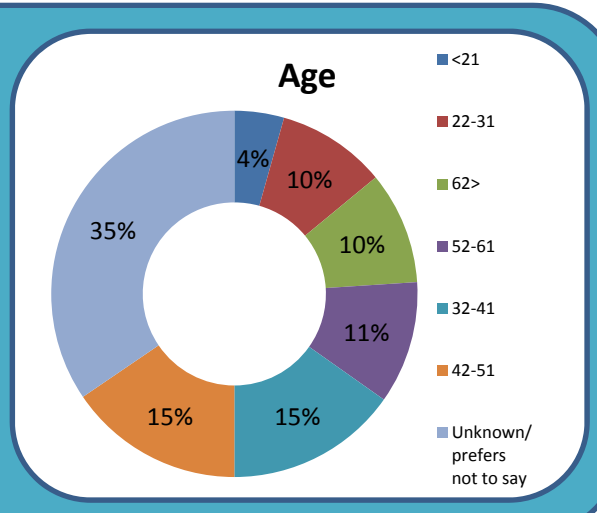
The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and request additional information from the Trust on occasion.

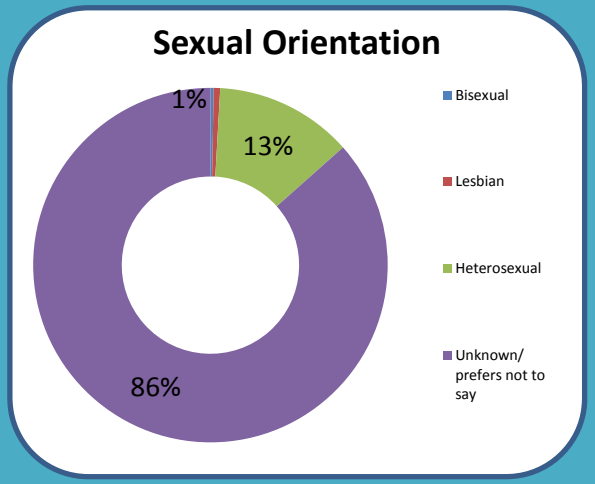
Healthwatch are encouraging local people to share their experience of health services via their websites and will theme and share feedback as data is collected and collated.

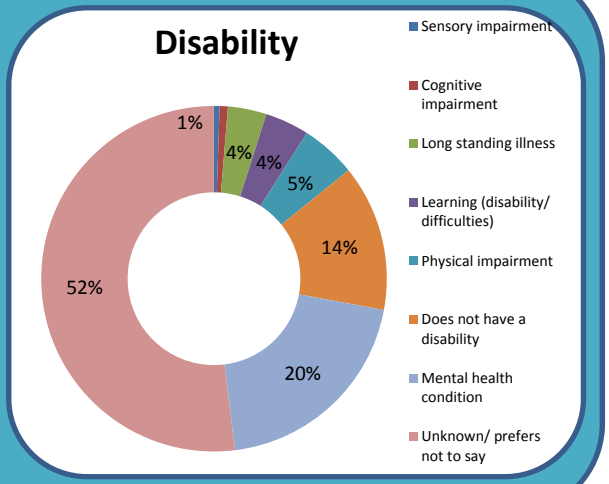
Equality and Inclusion – Formal Complaints - Protected Characteristics Data











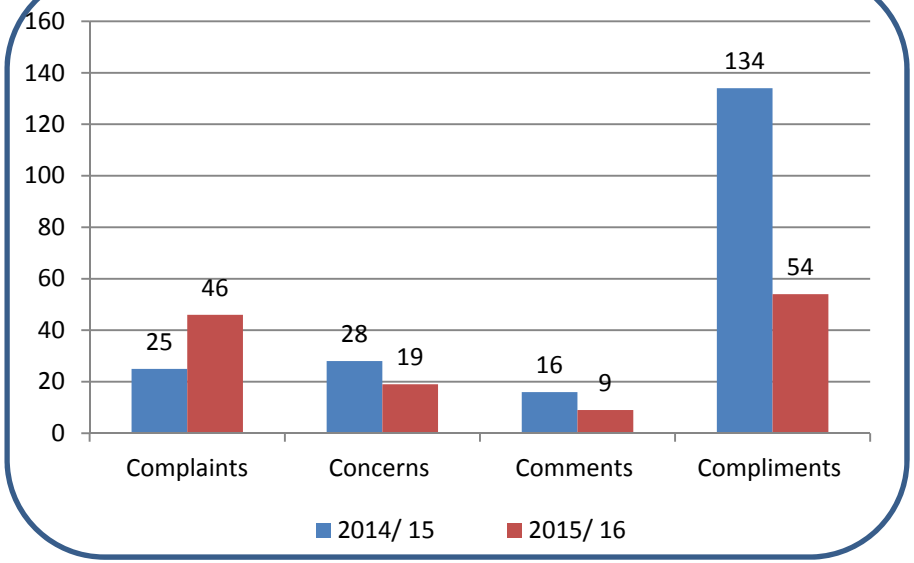
The charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. This is collated Trust- wide.

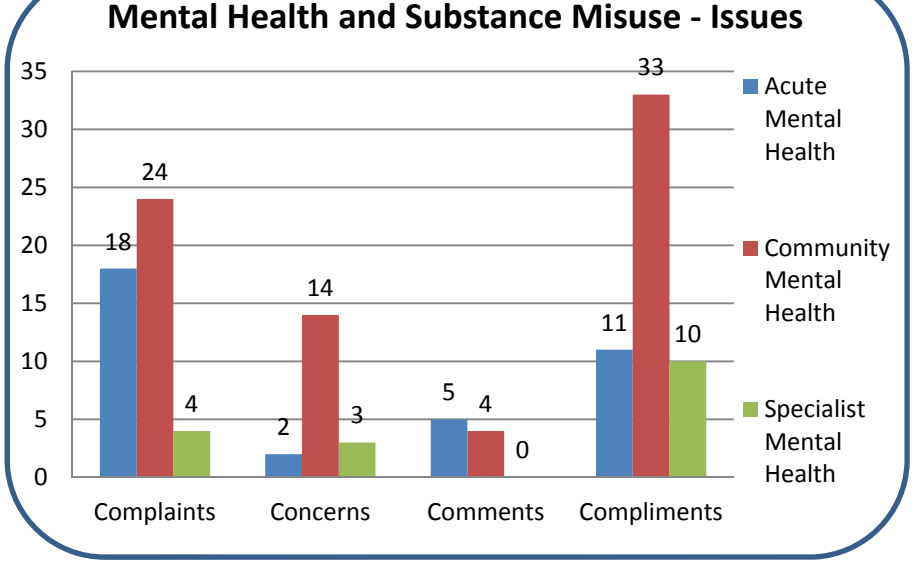
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. To support improvement in the number of forms returned / completed, additional information 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.

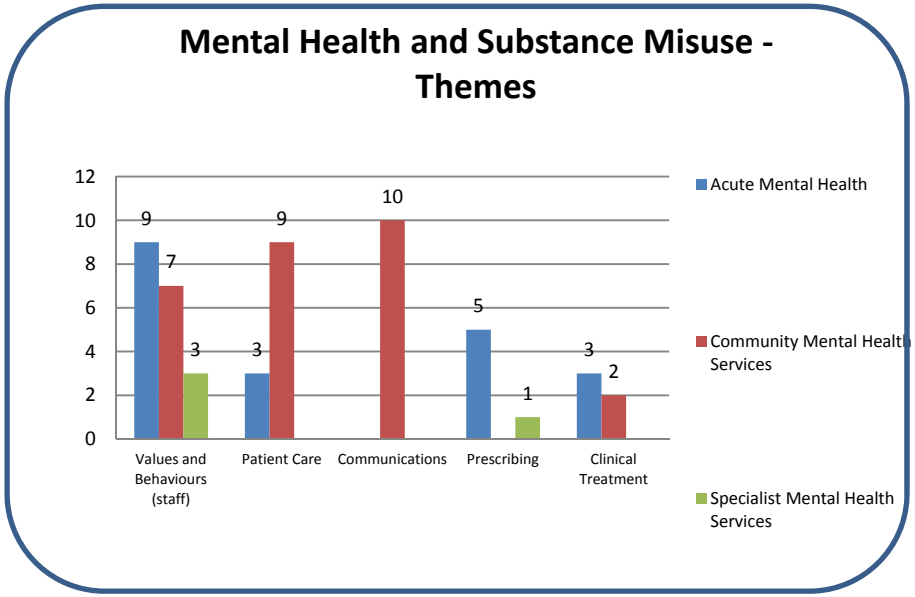
The Team continues to explore best practice in data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

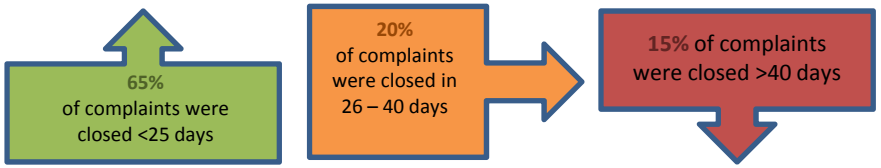
Barnsley Business Delivery Unit – mental health & substance misuse

Number of issues



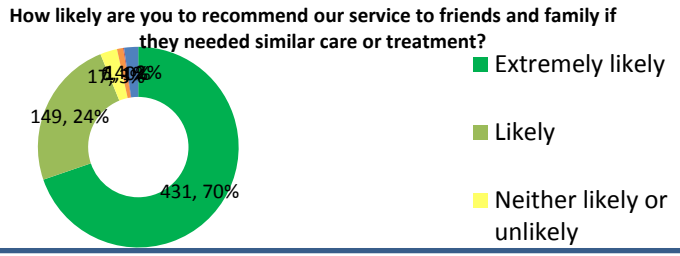






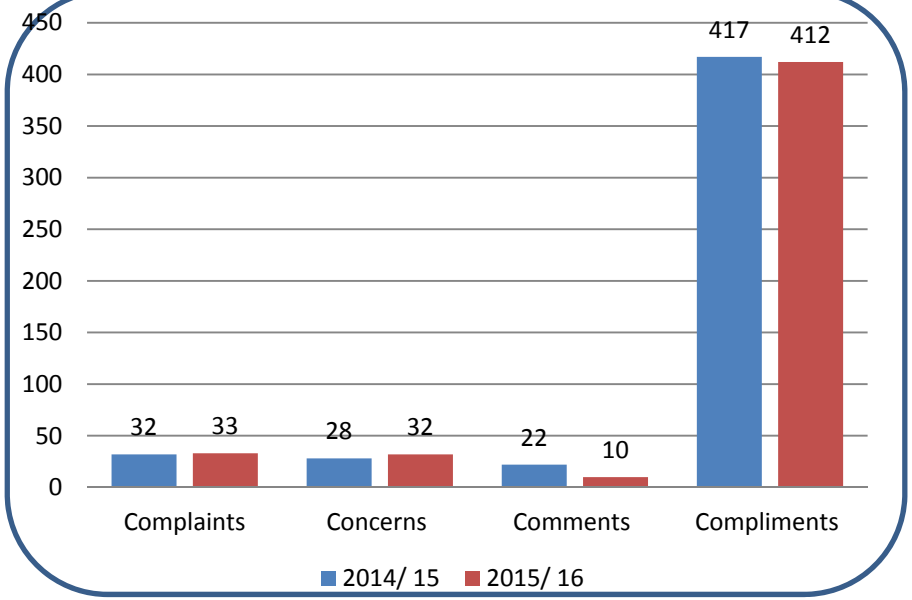
Complaints closed over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases.

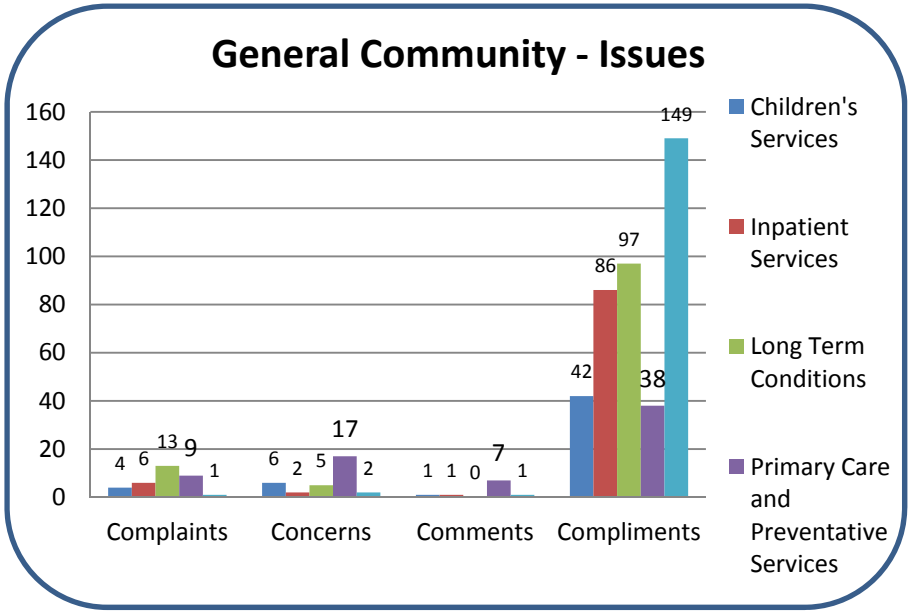
Friends and Family Test

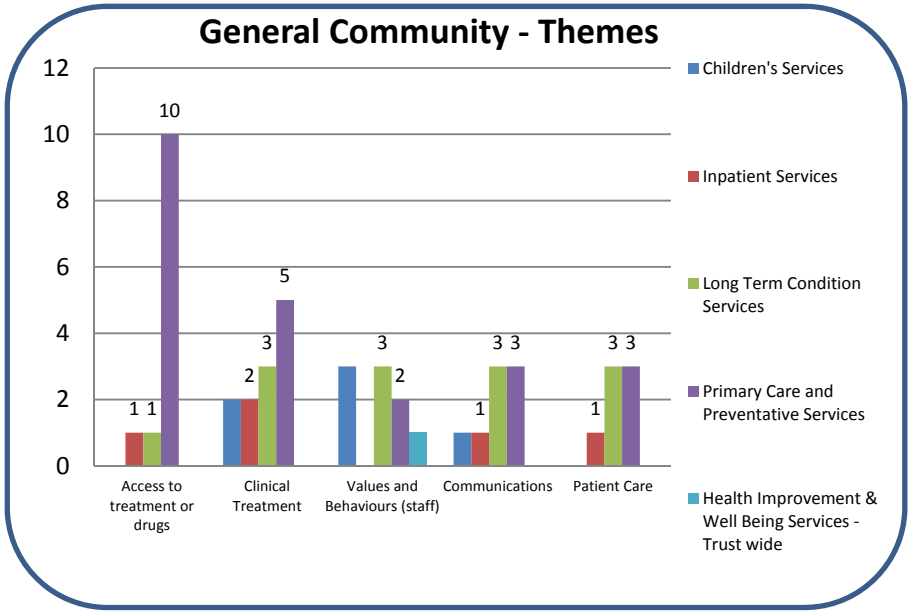


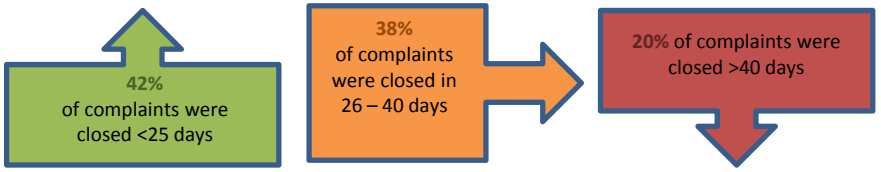
Barnsley Business Delivery Unit – general community services

Number of issues







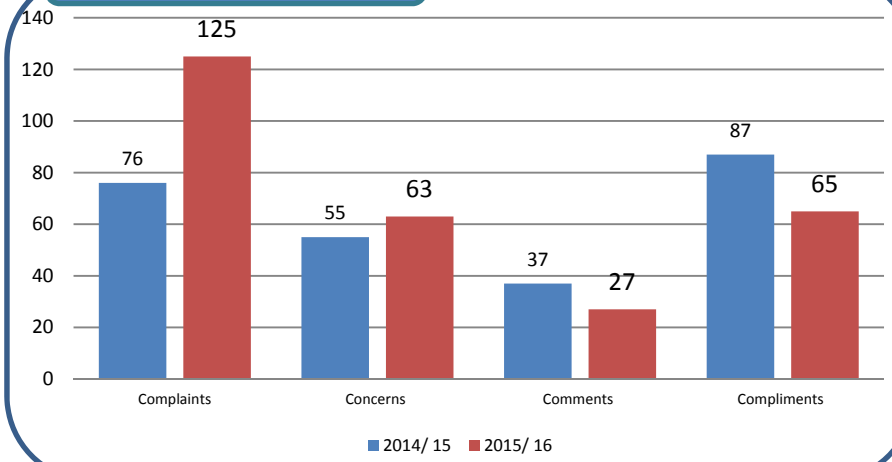


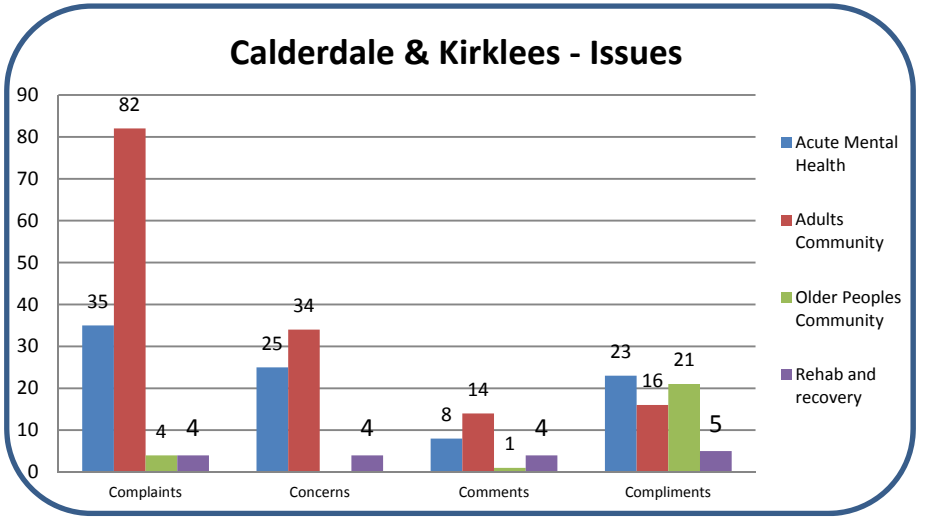
Complaints closed over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases.

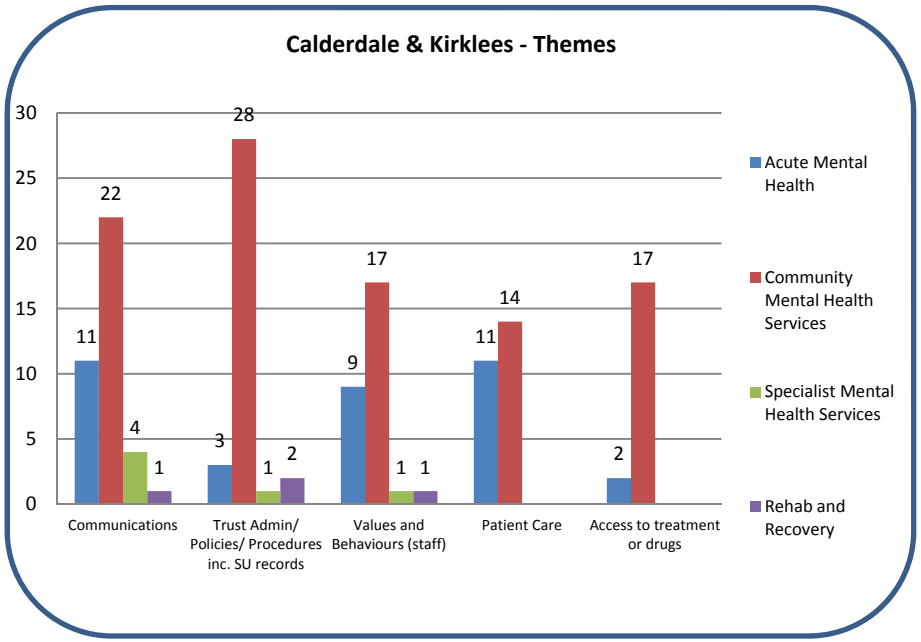
Friends and Family Test

Calderdale & Kirklees Business Delivery Unit

Number of issues







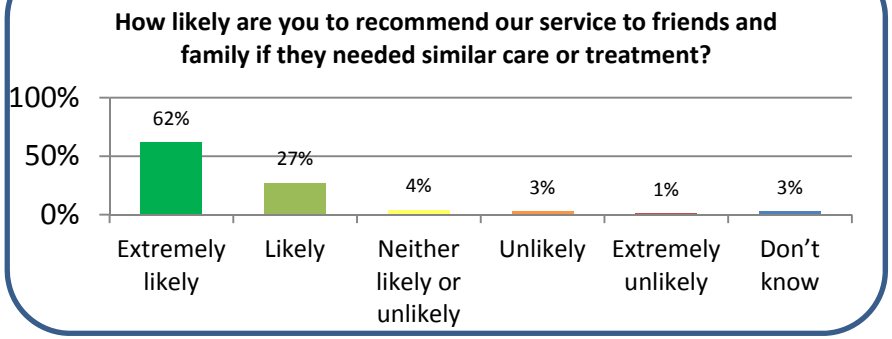
52% of complaints were closed <25 days

27% of complaints were closed in 26 – 40 days

21% of complaints were closed >40 days

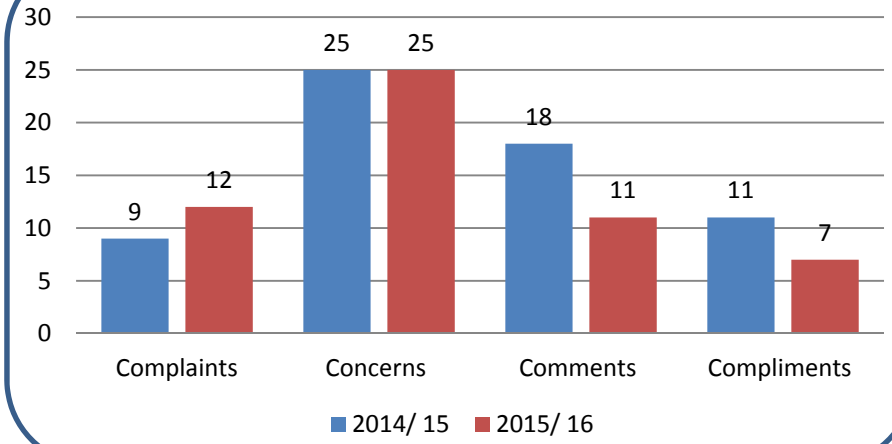
Complaints taking over 40 days were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. During Qtr 4 64% of complaints were closed within 25 days.

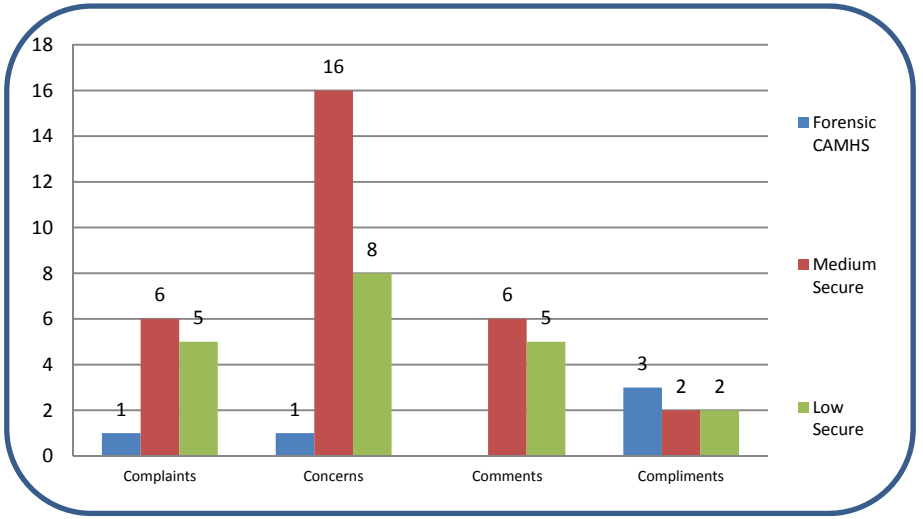
Friends and Family Test

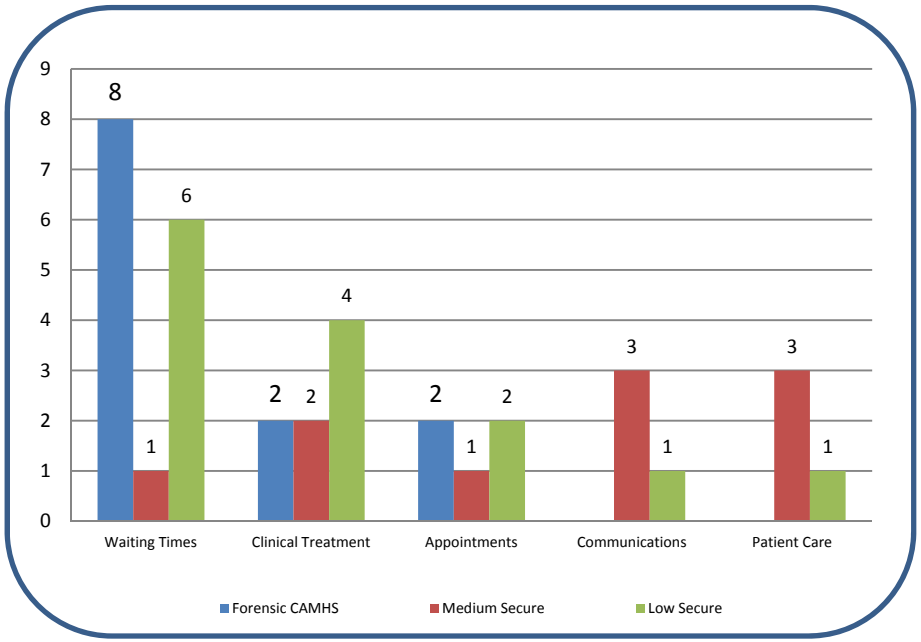


Forensics Business Delivery Unit

Number of issues







50% of complaints were closed <25 days

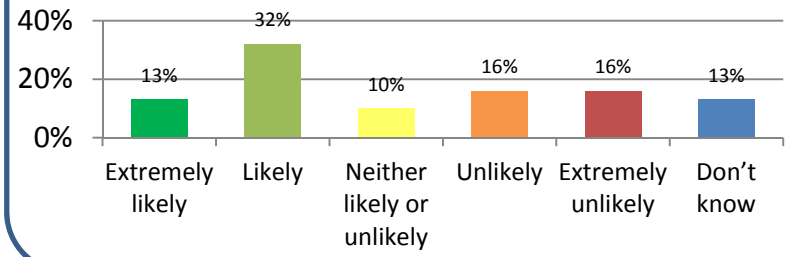
25% of complaints were closed in 26 – 40 days

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.

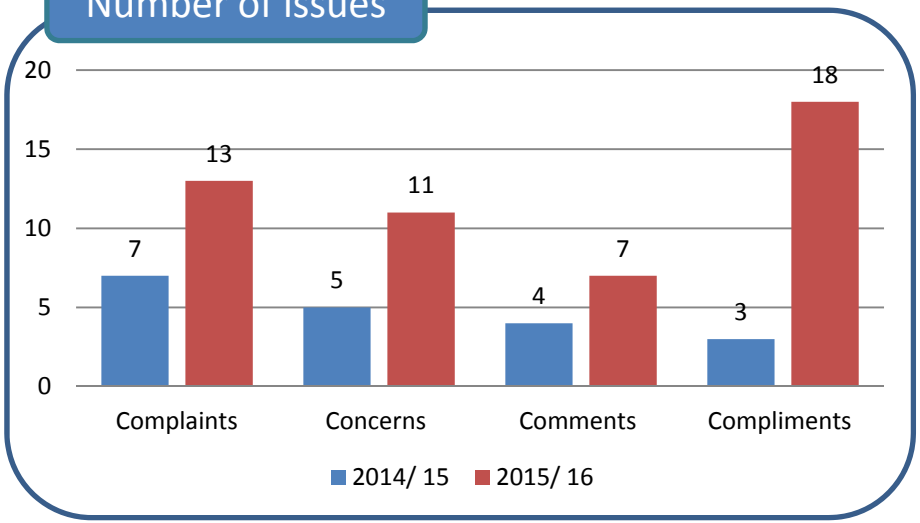
Friends and Family Test

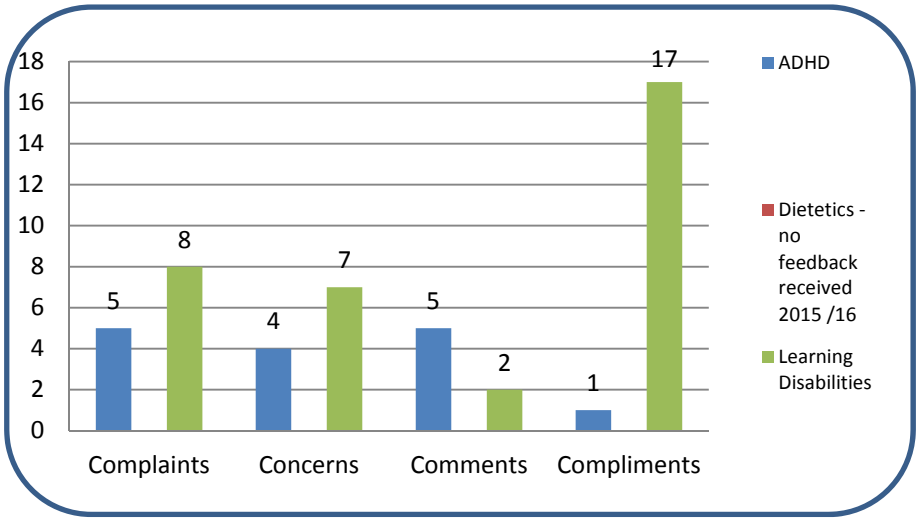
How likely are you to recommend our service to friends and family if they needed similar care or treatment?

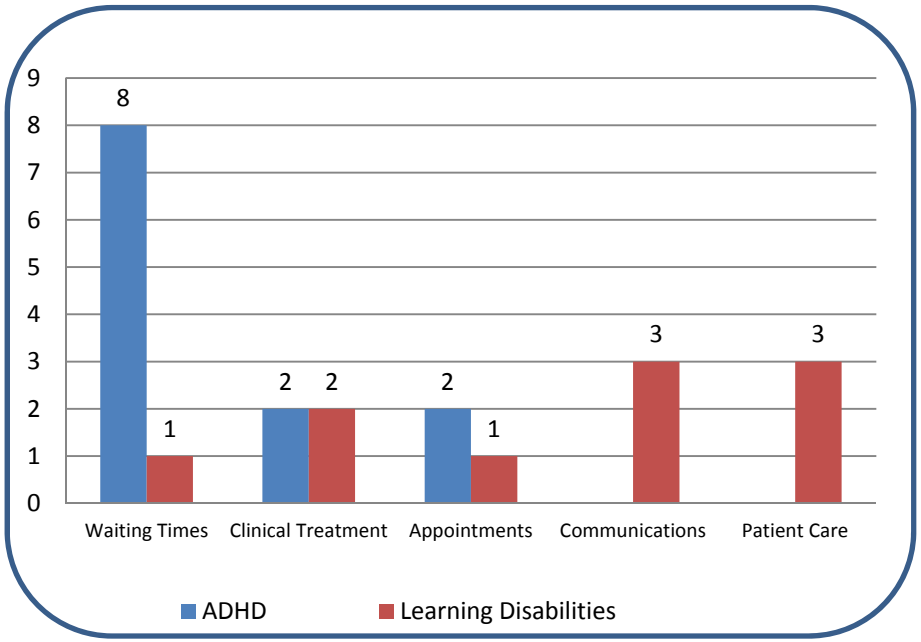


Specialist Services Business Delivery Unit (excluding CAMHS)

Number of issues







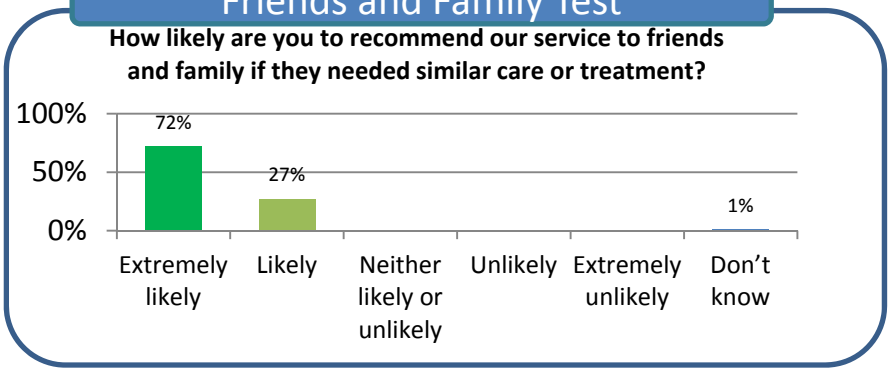
56% of complaints were closed <25 days

0% of complaints were closed in 26 – 40 days

45% of complaints were closed >40 days

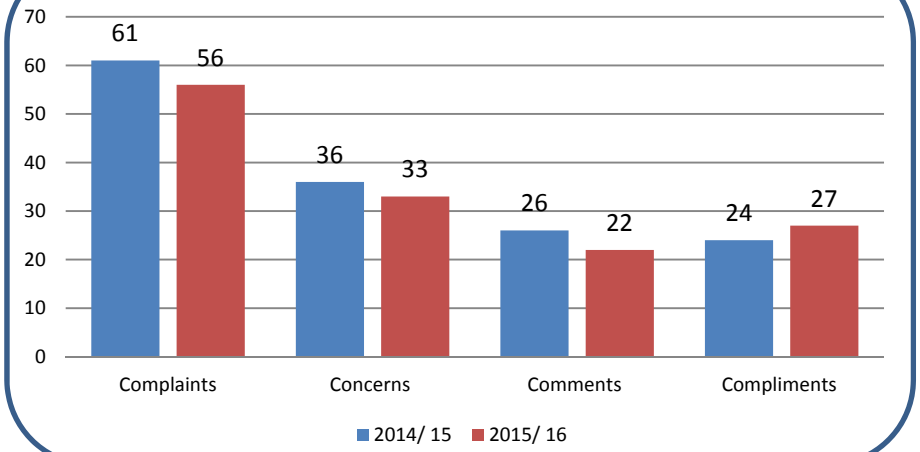
Complaints taking over 40 days to close were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. In Qtr 4, 100% of cases closed within 25 days.

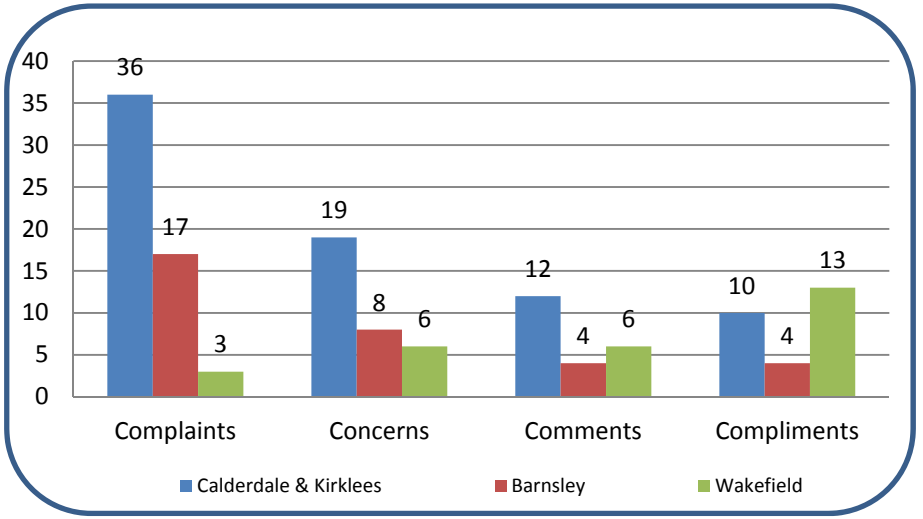
Friends and Family Test

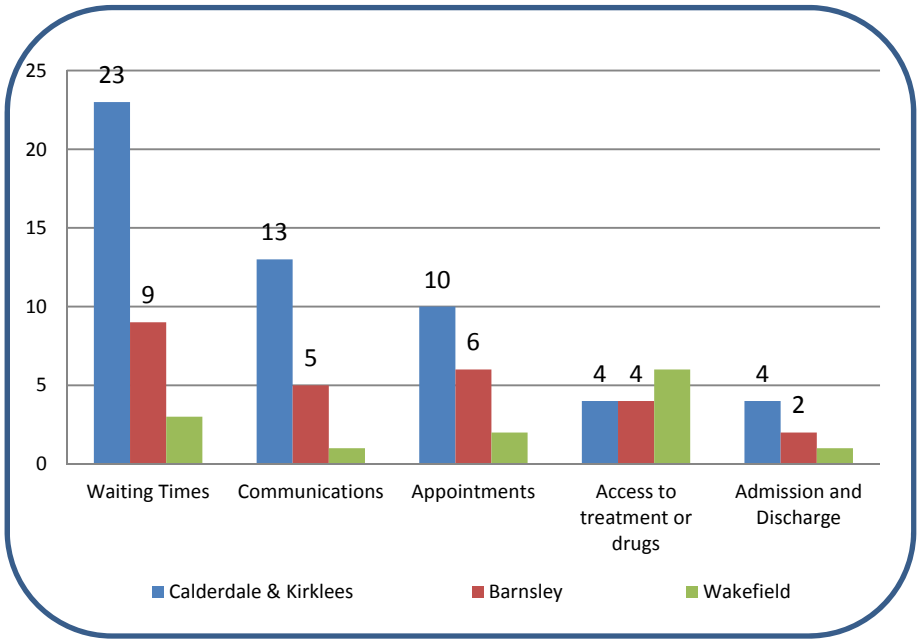


Child and Adolescent Mental Health Services

Number of issues







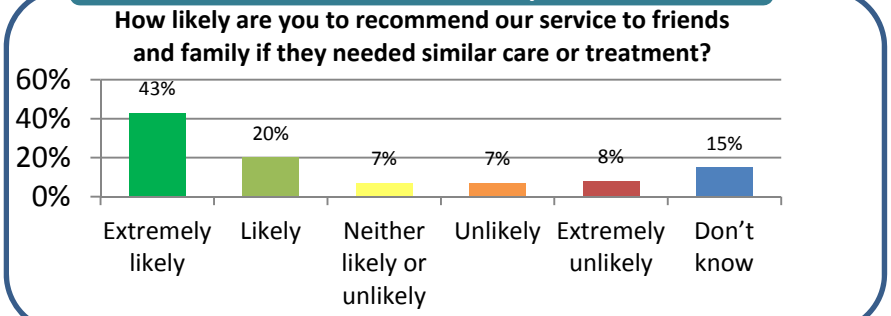
40% of complaints were closed <25 days

18% of complaints were closed in 26 – 40 days

36% of complaints were closed >40 days

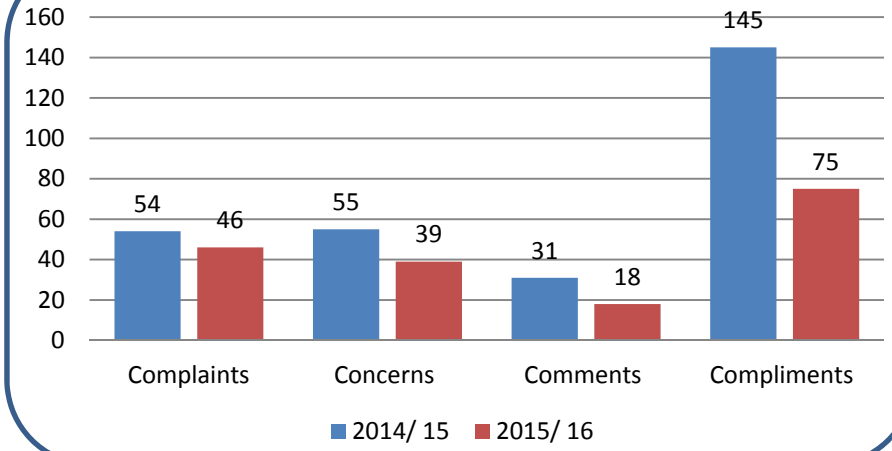
Complaints taking over 40 days to close were due to delay in investigation at BDU level (allocation of a lead investigator) and the length of time to investigate. Deputy directors and general managers are alerted in such cases. In Qtr 4, 64% of cases were closed within 25 days.

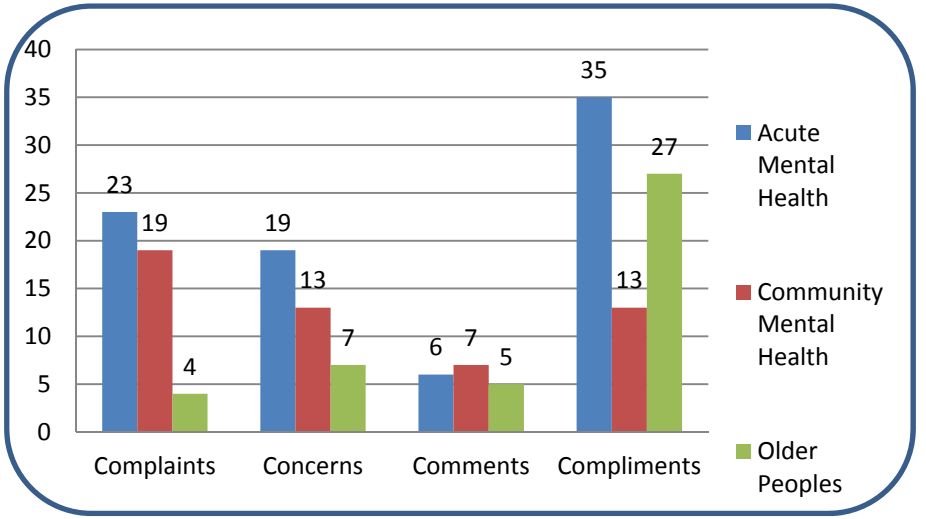
Friends and Family Test

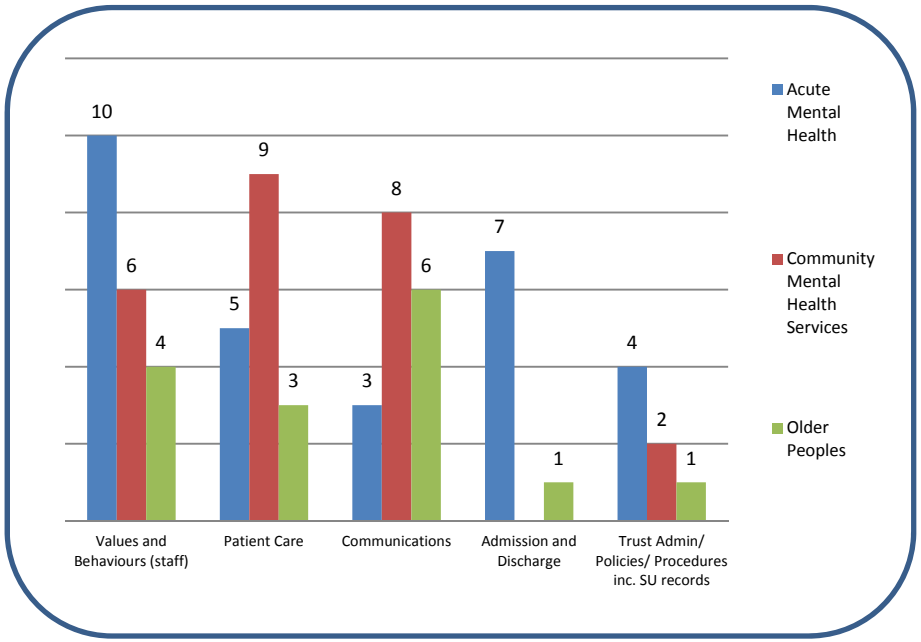


Wakefield Business Delivery Unit

Number of issues







44% of complaints were closed <25 days

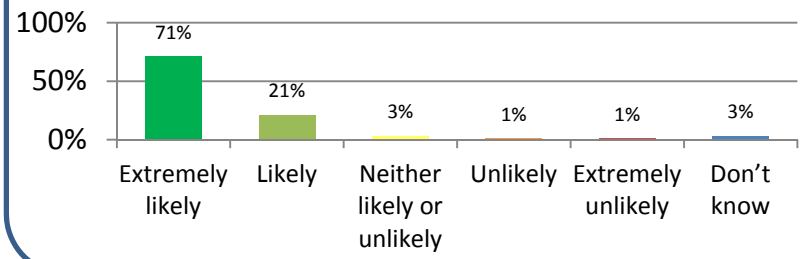
18% of complaints were closed in 26 – 40 days

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.

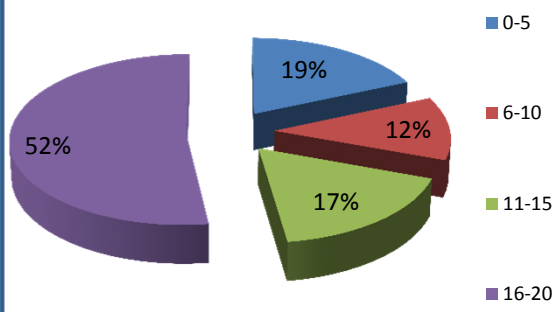
The Customer Services Team works with information owners in the Trust to respond to requests as promptly as possible, but within the 20 working day requirement.

During the year, 5 exemptions were applied –

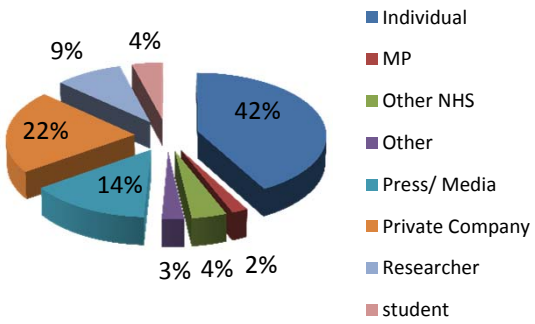
- 2 under section 41 - public sector contracts,
- 2 under section 43 - commercial interests
- 1 under section 40 - personal information.

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.

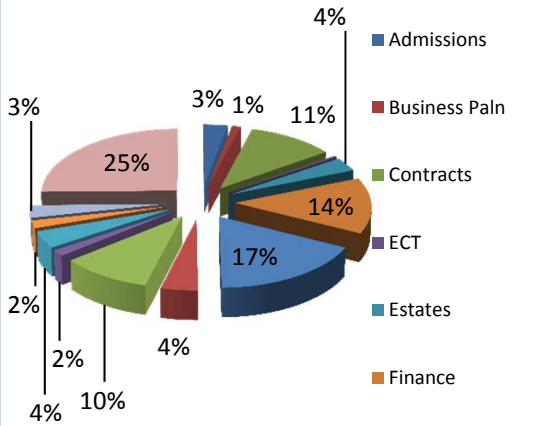
Number of days to respond



Origin of request



Types of request



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.

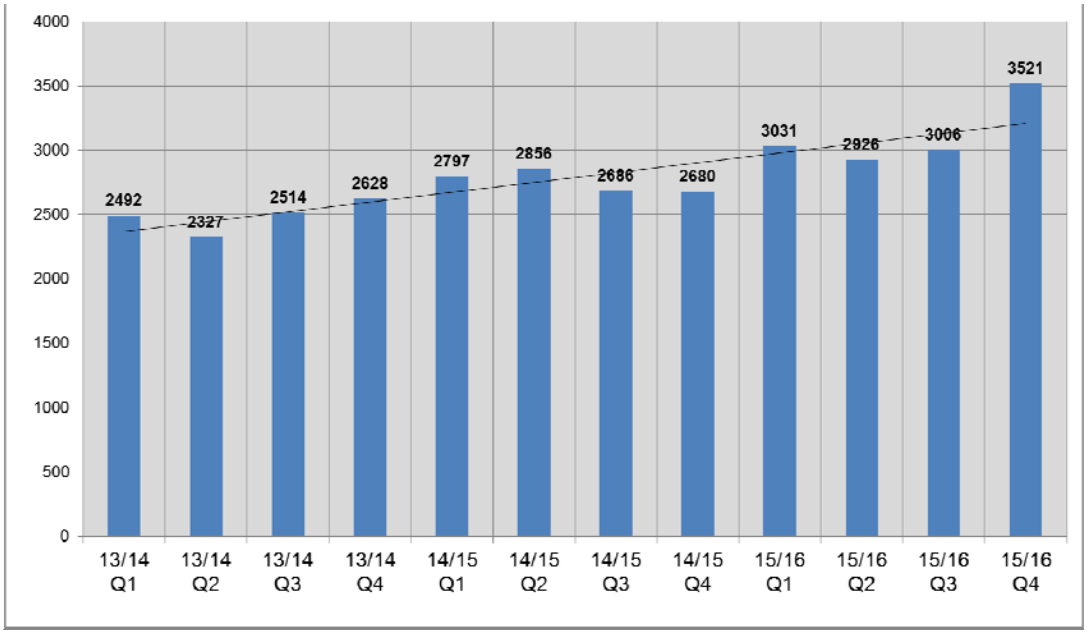
The investigators are working with the practice governance coaches to produce a report for each BDU on the learning from incidents; these will be available in quarter 2 2016.

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

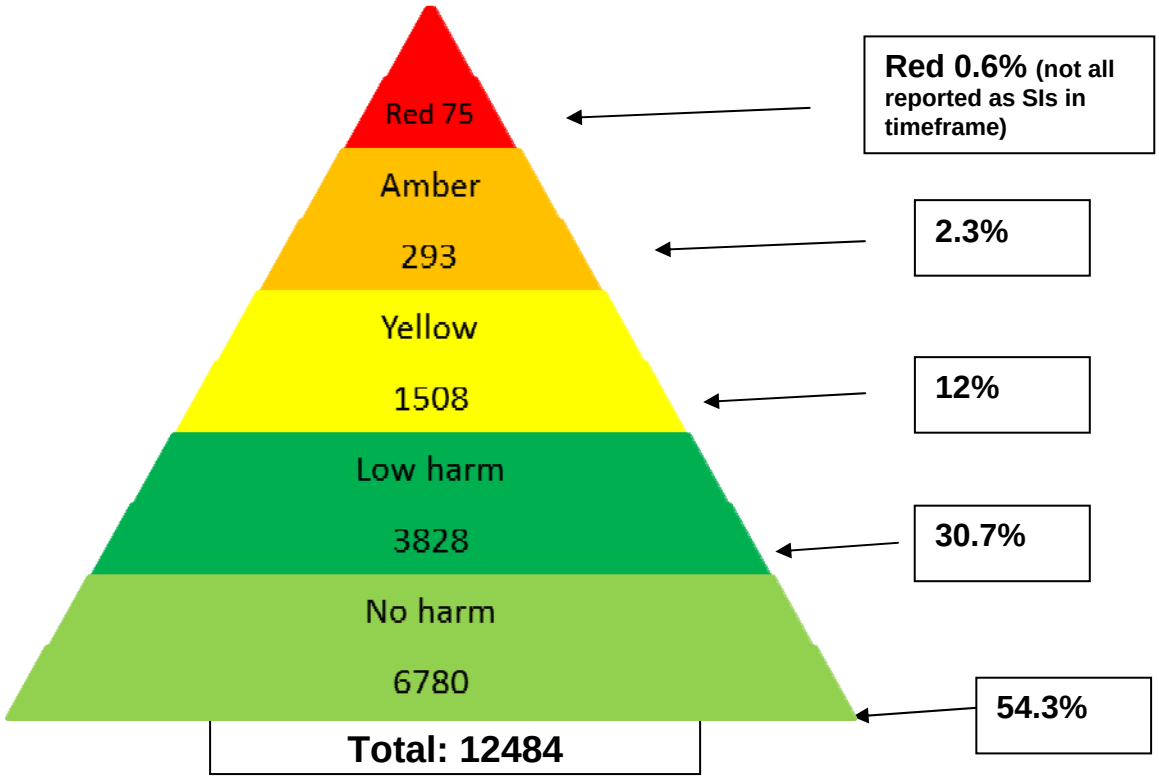
The Trust reported **12484** incidents of all severity during the year, a 13% increase on 2014/15 (1494 additional incidents being reported). The range within a quarter is 2926-3521 incidents.

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

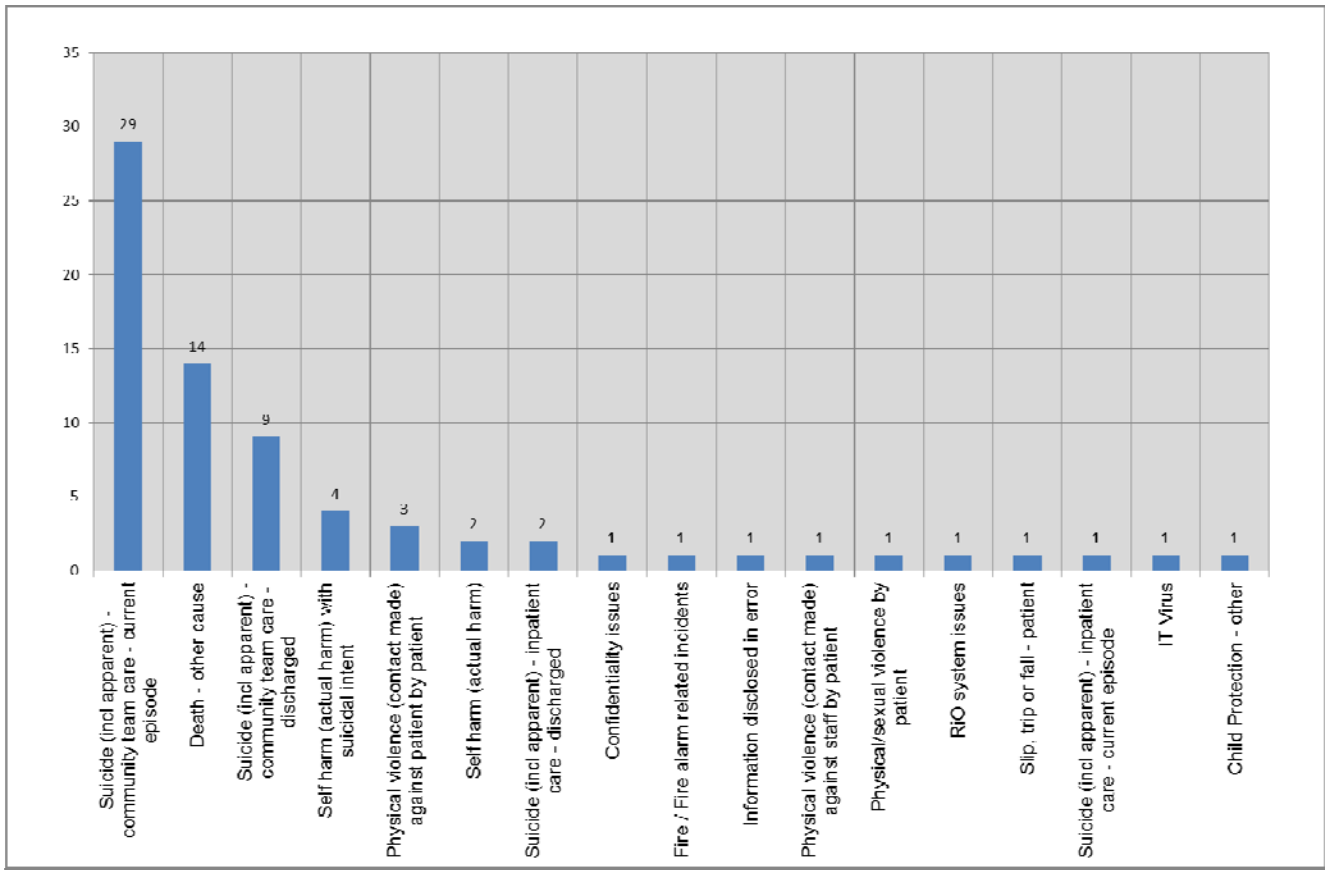


Serious incidents are defined by NHS England, they are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. There 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

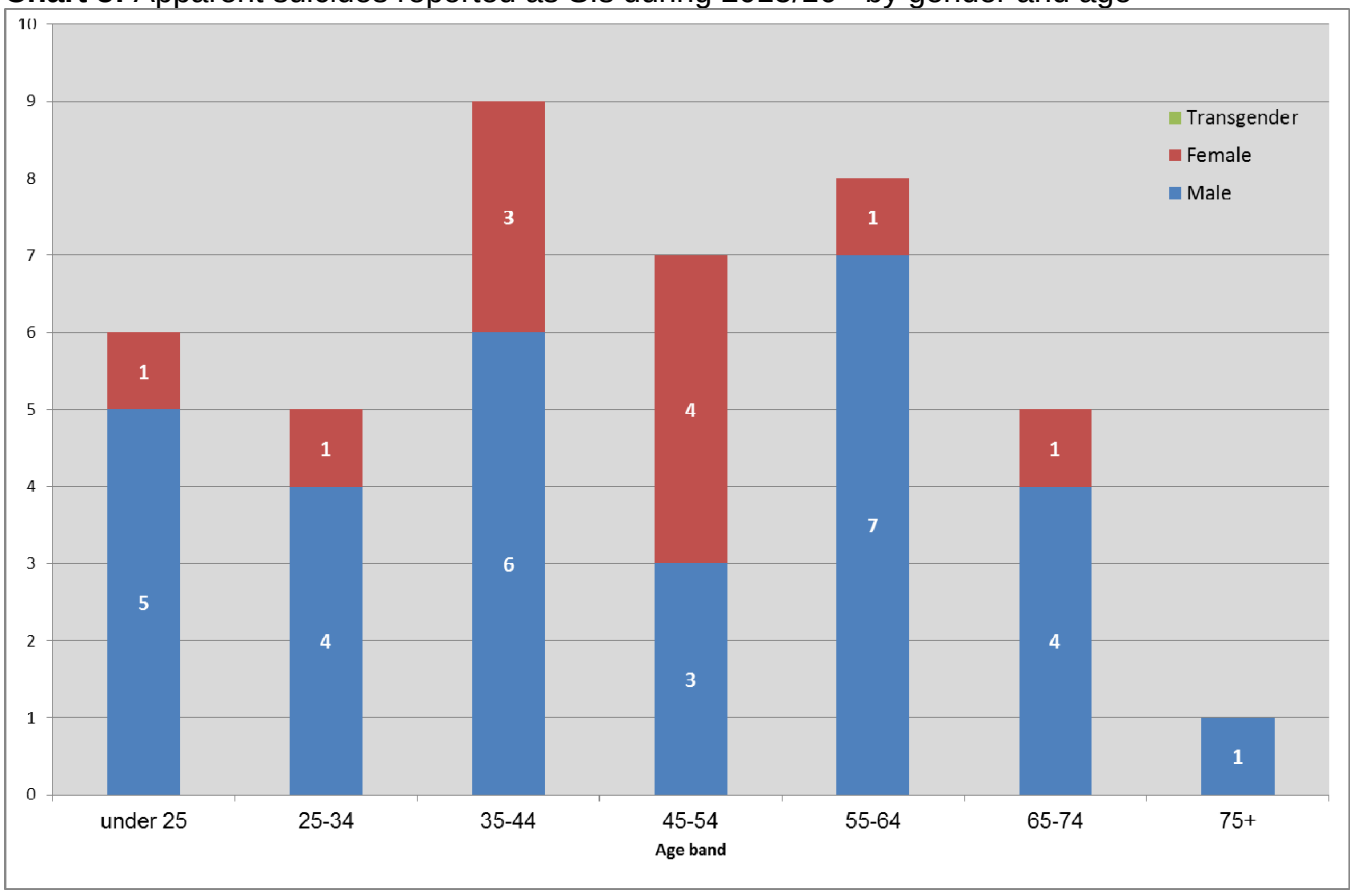


Chart 5 shows the gender and age distribution of all apparent suicides reported during 2015/16. There were no transgender service users. Of the 41 suicides/suspected suicides, (11 female,30 male) In terms of age, the highest proportion of apparent suicide in males occurred between the ages of 55-64 (17%), 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

Members' Council
22 July 2016

Agenda item:	**11.1**
Report Title:	Appointment of Lead Governor
Report By:	Ian Black
Job Title:	Chair
Action:	To agree

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to seek the Members' Council approval for the appointment of a Lead Governor.

Recommendation

The Members' Council is asked to CONSIDER and AGREE the proposal from the Nominations Committee.

Background

From October 2009, Monitor (now part of NHS Improvement) requires all foundation trusts to appoint a Lead Governor. The main duties of the Lead Governor are to:

1. act as the communication channel for direct contact between Monitor/NHS Improvement and the Members' Council;
2. chair any parts of Members' Council meetings that cannot be chaired by the person presiding (that is, the Chair or Deputy Chair of the Trust) due to a conflict of interest in relation to the business being discussed;
3. be a member of Nominations Committee (except when the appointment of the Lead Governor is being considered);
4. be involved in the assessment of the Chair and Non-Executive Directors' performance; and
5. be a member of the Co-ordination Group to assist in the planning and setting of the Members' Council agenda.

The individual appointed should be confident they can undertake the duties outlined above and be able to deal with senior personnel at Monitor/NHS Improvement should the need arise. The individual should also need to:

- have the confidence of Governors and of Trust Board;
- be able to commit the time necessary should the need arise, which may be at very short notice;
- have excellent communication skills, including the ability to influence and negotiate;

- be able to present a well-reasoned argument;
- be committed to the success of the Trust and to its mission, vision, values and goals;
- be able to demonstrate experience of chairing both large and small meetings effectively;
- have the ability to work with others as a team and to encourage participation from less experienced Governors;
- demonstrate an understanding of the Trust's Constitution and how the Trust is influenced by other organisations.

The Members' Council agreed at the time that the Lead Governor should be appointed from publicly elected governors and this process should be overseen by the Nominations Committee. The process was agreed as follows.

1. Publicly elected Council Members would be invited to self-nominate supported by a brief written explanation of why they are putting themselves forward and evidencing how they would be able to fulfil the role.
2. The Nominations Committee would consider the self-nominations and invite shortlisted candidates to make a brief presentation and answer questions based on their 'application'.
3. The Nominations Committee would then consider the self-nominations and make a recommendation to the full Members' Council.

Michael Smith, publicly elected Governor for Calderdale, was the Lead Governor up to 30 April 2016; however, he was not re-elected as a Governor leaving the post vacant.

Process

The Chair invited expressions of interest from publicly elected Governors at the Members' Council meeting in May 2016 and also discussed the role with Governors at their annual review meetings early in 2016.

One expression of interest was received from Andrew Hill, publicly elected Governor for Barnsley. The Chair asked that the Nominations Committee consider the self-nomination made by Andrew and highlighted the significant time, commitment, passion and skill Andrew has demonstrated during his time on the Members' Council.

The Chair strongly recommended Andrew as an outstanding candidate to assume the role of Lead Governor.

Outcome

The Nominations Committee supported the recommendation from the Chair to appoint Andrew Hill as Lead Governor for a period of two years, subject to his re-election as a governor in 2017, from 22 July 2016 to 30 April 2018 with the option to extend the appointment for a further year to 30 April 2019. This forms the recommendation to the Members' Council.

Recommendation

The Members' Council is asked to AGREE the recommendation from the Nominations Committee to appoint Andrew Hill as Lead Governor for a period of two years, subject to his re-election as a governor in 2017, from 22 July 2016 to 30 April 2018 with the option to extend the appointment for a further year to 30 April 2019.