South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 27 June 2017 at 10:00am
Rooms 49/50, Folly Hall, Huddersfield

AGENDA

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

2. **Declaration of interests** (verbal item)

3. **Minutes and matters arising from previous Trust Board meetings held 25 April 2017 and 23 May 2017** (attached)

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

5. **Performance reports month 2 2017/18**

   5.1. Integrated performance report month 2 2017/18 including finance (attached)

6. **Exception reporting**

   6.1. Incident management annual report 2016/17 (attached)

   6.2. Customer services annual report 2016/17 (attached)

7. **Governance matters**

   7.1. Update on annual report, accounts and quality account 2016/17 (attached)

   7.2. NHS England managing conflicts of interest guidance (attached)

   7.3. Safe working hours: Doctors in training quarterly report (attached)

   7.4. Customer services policy (attached)

   7.5. Receipt of public minutes of partnership boards (attached)

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

- Clinical Governance and Clinical Safety Committee 11 April 2017 (minutes attached), 22 May 2017 (minutes attached) and 13 June 2017

- Equality & Inclusion Forum 16 May 2017

- Mental Health Act Committee 16 May 2017 (draft minutes attached)

- Nominations Committee 13 June 2017

- Remuneration & Terms of Service Committee 23 May 2017

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

10. **Trust Board Work Programme** (attached)

11. **Date of next meeting**

The next meeting of Trust Board will be held on Tuesday 25 July 2017 in the Conference Centre Boardroom, Kendray, Barnsley.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 25 April 2017

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Chris Jones	Non-Executive Director
	Rob Webster	Chief Executive
	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Tim Breedon	Director of Nursing and Quality
	Mark Brooks	Director of Finance and Resources
	Alan Davis	Director of HR, OD and Estates
Apologies:	Julie Fox	Deputy Chair
	Rachel Court	Non-Executive Director
In attendance:	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Kate Henry	Director of Marketing, Communications and Engagement
	Salma Yasmeen	Director of Strategy
	Emma Jones	Integrated Governance Manager (author)

TB/17/30 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting. Apologies were received as above. IB advised that one of the Governors, Michael Fenton had sadly passed away on 7 April 2017. The Trust Board and those in attendance observed a minute's silence.

Prior to the meeting, the Board received a session on the Mental Capacity Act 2005 and Mental Health Act 1983 (2007).

TB/17/31 Declaration of interests (agenda item 2)

There were no declarations over and above those made annually in March 2017 or subsequently.

TB/17/32 Minutes and matters arising from previous Trust Board meeting held on 28 March 2017 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 31 January 2017 and 28 February 2017 as a true and accurate record of the meetings.

TB/17/33 Chair and Chief Executive's remarks (agenda item 4)

IB highlighted that the elections to the Members' Council had taken place with six new governors elected and three governors re-elected. As part of the election the Lead Governor Andrew Hill was not re-elected and a process would commence at the Members' Council meeting on 28 April 2017 for Lead Governor nominations. He passed on his thanks for the diligent way in which Andrew had carried out his role as lead governor

Rob Webster (RW) highlighted the following:

- A snap general election has been called for June 2017. The NHS will feature as an election issue and this will provide some leverage for the national representative bodies with Government. RW has written to NHS Providers, the NHS Confederation and others emphasising the need to work together. During the election period, there may be a delay in some decisions due to the "purdah" period and guidance on this has been circulated to the Board.
- The Five Year Forward View next steps document had been published. Subsequently Sustainability and Transformation Plan (STP) leaders had been asked to coordinate an initial list of developments which require capital investment. This process will deliver the investment highlighted in the last Budget by the Chancellor. RW also asked the Board to note that the South Yorkshire STP had been approached as one of the first STPs to be an "Accountable Care System" taking more local control of its own affairs.
- Final Care Quality Commission (CQC) reports have been published with the Trust rated "Good" overall. Face to face meetings had been held with staff and information sent to stakeholders on the day before publication.
- The Brief to staff next week would include a look back on 2016/17 to take stock of what has been achieved across the year. This included higher quality services according to CQC, delivery of our financial duties, transformation of services, and people working in different ways.
- NHS Improvement had advised that an additional payment would be made to the Trust for achieving and exceeding the required control total.

Charlotte Dyson (CD) asked if the results from the CQC inspection would be used to raise the Trust's profile nationally. Kate Henry (KH) commented that it provided an opportunity around both sharing our achievements and approaches to safety and innovation. There was little appetite from local and national trade media for covering moves to "Good" ratings.

Chris Jones (CJ) commented that continued focus on improvement was important and the Integrated Performance Report could be used as a self-assessment tool. Tim Breedon (TB) commented that the Clinical Governance and Clinical Safety Committee receive an annual report on internal visits, reporting against mock visits, and results from CQC inspections. Mock inspections would be themed into services and included in the quality reporting through the Integrated Performance Report.

It was RESOLVED to NOTE the content of the Chair's remarks and the Chief Executive's report.

TB/17/34 Strategic overview of business and associated risks (agenda item 5)

Salma Yasmeen (SY) report that the format of the paper had been changed to reflect and align with the risk register and priority programmes. The paper supports the Board in understanding the external environment and the Trusts readiness and strategic alignment. SY highlighted the following:

- PESTLE (Political, Economic, Social, Technological, Legal and Environmental) analysis included the Five Year Forward View next steps document, impact on establishment of Accountable Care Organisations, change in market conditions such as IR35 rules, impact on partnership working in social care, targeted at system flow, and delayed transfers of care. Eight out of forty entries could be matched against risks that are being managed on the risk register, with the majority managed within the risk tolerance. It was important to note that not every entry constitutes a risk.

- SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis included the positive results from Care Quality Commission inspection, opportunities aligned and reviewed against emerging strategy and those through STPs, provider alliance arrangements that are beginning to demonstrate progress with integrated care agenda, and financial risks from contractual changes. Most entries could be matched against risks on the risk register with most managed within risk tolerance level.

RW commented that a direct association between the assurance framework and risk register and the PESTLE and SWOT was not possible to deliver. Instead, the assurance framework and risk register inform are informed by the PESTLE and SWOT, which interact. They also could be linked in with a private paper which looks at opportunities for the Trust. This information could then be used to inform the strategy and operational plan.

The Board discussed that it was useful for the report to be linked to strategic objectives and further work was need to clarify weaknesses, opportunities and strategies for improvement. Nothing within the paper this quarter's report suggested that the Trust needed to change direction. The next update would need to be updated to reflect the impact of the election.

Action: Salma Yasmeen

It was RESOLVED to NOTE the content of the report and that updates would be received every six months.

TB/17/35 Strategies (agenda item 6)

TB/17/35a Digital strategy (agenda item 6.1)

KH reported that the strategy outlined how the Trust could become digital to help enable its vision. The strategy had been developed through input from staff, service users, carers, the extended Executive Management Team, and specialists. The strategy focused on the use of digital technology to address current challenges and future goals and sets out principles that underpins how the Trust will engage:

- Digital health best practice – priority area in Sustainability and Transformation Plans (STPs).
- Digital in practice and support staff – ensuring staff have the skills to take it forward.
- Digital inclusion – for all people, including traditionally excluded groups including those over 65, disabled people, low income families, and those living in social housing.

Further work would take place to develop key performance indicators (KPIs) and an action plan during Quarter 1. Services would be identified for targeted focus and prioritising of resources, including services that are responsive and ready and areas of interest working with commissioners.

SY commented that work would take place with the leads of all strategies to identify clear actions that are measurable, will deliver the overall strategy, and have a better outcome for the end user.

The Board discussed that there should be measurable and ambitious KPIs linked to the three principles with clear milestones for achievement that are measurable. There were already several areas that were using digital technology and it was important to communicate those achievements, enable access, and provide support which fits in with the principles of the strategy.

It was RESOLVED to APPROVE the digital strategy.

TB/17/36 Performance reports (agenda item 7)

TB/17/36a Integrated performance report month 12 2016/17 including finance (agenda item 7.1)

TB highlighted the following in relation to quality:

- Data issues continue with the national collection around medicines omissions.
- Disappointing outcome on CQUINS and need to focus on a new area in 2017/18.
- Safety first incident reporting is within the anticipated range. However a report into the issues behind the downward trend in incidents would be prepared and would be received as part of the detailed Quarter 4 report.
- New system provisions to support the changes to the mortality review process have shown evidence of working well, awaiting further guidance on the requirements.
- Serious Incidents in Quarter 4 were higher than previous quarters, some due to pressure ulcers and Information Governance breaches.
- A review would take place on the percentage fill rates in specialist services by the safer staffing group.
- Care Quality Commission (CQC) reports received rated "good" overall and acute mental health showed areas of improvement, however rated "requires improvement" overall. Action plans underway to address "must do" and "should do" requirements. In comparison to 55 mental health and community trusts, we are in top quartile around safe domain.

CD asked for assurance that clinicians were comfortable reporting incidents. Alan Davis (AGD) advised as part of the staff survey they are asked if they know how to report incidents, if they have reported, and if they feel safe to. The significant majority of staff reported positive feedback here. The last area's result was below average for similar trusts and would be an area of focused work. TB commented that further feedback was received that after people reported an incident they were not receiving feedback on the outcome and work was taking place on how it could be reported back from operational groups as part of the patient safety strategy.

AGD highlighted in relation to workforce that an area for focus was around sickness absence in inpatient units and a health trainer had been appointed to do a significant piece of work. Further work was being done on hotspots around the completion of mandatory training and turnover rates.

CD asked how quickly the gap in completion of Mental Health Act and Mental Capacity Act training could be addressed. TB commented that the figures within the report would improve, however there would be a shortfall with an aim for completion before the end of Quarter 1.

CJ asked how mandatory training could be linked to behaviors and gave the example that while Information Governance training was compliant there was an increase in incidents. AGD commented that some areas are addressed in the staff survey and quality reporting and that increased awareness could also lead to an increase in reporting. RW commented that internal audit processes could also provide assurance.

Mark Brooks (MB) highlighted in relation to Information Governance (IG) that there had been an increase in incidents with two reported to Information Commissioners Officer. Actions were taking place included a focus on culture, impact for staff and service users, and system issues. There was not a set pattern of incidents and internal consequences for breaches may need to be considered in the future if they continue.

MB highlighted in relation to NHS Improvement matrix that there were areas that were showing improvement and further work taking place around data completeness for the new metric introduced during the course of the year.

MB highlighted the following in relation to finance:

- Revised control total delivered which enabled the Trust to receive matched funding.
- Overspend continuing on out of area beds. This has been reduced significantly with credit to staff for their ongoing work.
- Work is still continuing to address agency spend.

RW commented that it was important to maintain focus to ensure safe and sustainable services through discussion at the weekly risk scan and by the Executive Management Team. The CQC report showed two service lines that require improvement and a domain that requires improvement with the Quality Summit planned for June 2017 to explore some of the system issues with partners.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/17/36b Customer services report Q4 2016/17 (agenda item 7.2)
Dawn Stephenson (DS) reported that there was an ongoing focus around closing a number of complaints in line with indicators which was impacted by the availability of investigators. Working was taking place to ensure compliments are received in a timely manner, and the Friends and Family Test was showing an improvement to 87% recommend rate compared to 67% in the previous quarter.

IB asked about actions in place to improve areas of the Friend and Family Test. DS advised that a detailed report focusing on specific services and benchmarking could be provided to the Clinical Governance and Clinical Safety Committee.

Action: Dawn Stephenson

CD asked for further information regard the increase in complaints linked to values and behaviors. DS advised that while it was a small number and no trend had been identified it was an area of focus.

It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 4 of financial year 2016/17.

TB/17/37 Governance items (agenda item 8)

TB/17/37a Audit Committee annual report 2016/17 (agenda item 8.1), including approval of the Terms of Reference and Work Programme for Trust Board committees
Laurence Campbell (LC) as Chair of the Audit Committee reported that the work on the risk processes and introduction of risk appetite had strengthened the relationship across the committees. A very thorough review of each committee's annual report and terms of reference had taken place prior to the review by the Audit Committee.

CJ commented that further assurance was received at the Mental Health Act Committee through external partners attending.

RW commented that he would discuss with IB how any areas for improvement could be incorporated into the Board development programme.

Action: Rob Webster / Ian Black

It was RESOLVED to RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:

- **Committees meeting the requirements of their Terms of Reference;**
- **Committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
- **Committees can demonstrate added value to the organisation.**

It was RESOLVED to APPROVE the update to the:

- **Audit Committee Terms of Reference;**
- **Clinical Governance and Clinical Safety Committee Terms of Reference;**
- **Mental Health Act Committee Terms of Reference; and**
- **Remuneration and Terms of Service Committee Terms of Reference.**

TB/17/37b Draft annual governance statement 2016/17 (agenda item 8.2)
RW commented that the first draft had been reviewed in detailed by the Executive Management Team with the aim to make it shorter and more coherent. The text within the draft shaded in grey was mandated. The annual governance statement reflects the internal areas of control within the organisations and assurance through the scrutiny of the Board and its committees. The draft annual governance statement would be reviewed by the external auditors and the final version will be considered as part of the annual report and accounts for 2016/17.

It was RESOLVED to APPROVE the first draft of the Annual Governance Statement for 2016/17 and DELEGATE authority to the Audit Committee to approve a final version of the Statement as part of its approval of the Annual Report and accounts on 25 May 2017.

TB/17/37c Going concern basis (agenda item 8.3)
MB reported that there was a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. The auditors of the Trust would require evidence with respect to how that conclusion has been derived with the principles to be followed outlined in the paper.

It was RESOLVED to APPROVE the preparation of the 2016/17 annual accounts and financial statements on a going concern basis.

TB/17/37d Guardian of safe working hours (agenda item 8.4)
Dr Adrian Berry (ABe) reported that regular quarterly reports would commence from June 2017 as a requirement under the new junior doctor contract. Whilst there were currently concerns about some working patterns, plans were in place will address most of these issues. Any unresolved issues would be included in the next quarterly report to the Board.

It was RESOLVED to NOTE the report.

TB/17/38 Assurance framework and risk register (agenda item 9)

DS reported that the assurance framework had been received by the Executive Management Team (EMT) including each of the objectives, principle risks and rationale, looking at both the internal and external environment. The risk register has been reviewed and the EMT were reviewing risks below 15 with a summary of those that are outside of the risk appetite included at the end of the risk register appendix.

The Board discussed that the election may have an impact which was currently unknown. Further discussion to be had by the Board after the election, in line with the next strategic overview of business and associated risks report.

Action: Dawn Stephenson / Salma Yasmeen

It was RESOLVED to:

- **NOTE the controls and assurances against corporate objectives for Q4 2016/17; and**
- **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**

TB/17/39 Receipt of minutes of partnership boards (agenda item 10)

A list of agenda items discussed and Minutes where available were provided for the following meetings:

- Barnsley Health and Wellbeing Board held on 4 April 2017.
- Kirklees Health and Wellbeing Board held on 30 March 2017.
- Wakefield Health and Wellbeing Board held on 23 March 2017.

It was RESOLVED to NOTE the updates provided.

TB/17/40 Assurance from Trust Board committees (agenda item 11)

Audit Committee 4 April 2017

LC highlighted that the draft head of internal audit opinion showed significant assurance with minor opportunities for improvement.

Clinical Governance and Clinical Safety 11 April 2017

IB highlighted that different options need to be explored to address the waiting lists in Child and Adolescent Mental Health Services (CAMHS). RW commented that it would be discussed as part of the Quality Summit which will be held in June 2017. Across West Yorkshire, Mental Health providers have made it a priority area to work on reducing waits with local commissioners as it was a shared issue.

It was RESOLVED to NOTE the updates provided.

TB/17/41 Trust Board work programme 2017/18 (agenda item 12)

As discussed under agenda item 5, the work programme should be updated to receive the strategic overview of business and associated risks report every six months.

As discussed under agenda item 8.4, the work programme should be updated to receive a guardian of safe working hours report every quarter.

DS advised that guidance had been received from NHS Improvement for a Trust Board self-certification on compliance with NHS provider licence conditions due for submission at the end of May 2017. The annual item would be added to the work programme.

It was RESOLVED to update the work programme.

TB/17/42 Date of next meeting (agenda item 13)

The next meeting of Trust Board will be held on Tuesday 27 June 2017 in Rooms 49/50, Folly Hall, Huddersfield.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 23 May 2017

Present:	Ian Black	Chair
	Julie Fox	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Chris Jones	Non-Executive Director
	Rob Webster	Chief Executive
	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Tim Breedon	Director of Nursing and Quality
	Mark Brooks	Director of Finance and Resources
	Alan Davis	Director of HR, OD and Estates
Apologies:	Nil	
In attendance:	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Kate Henry	Director of Marketing, Communication and Engagement
	Salma Yasmeen	Director of Strategy
	Emma Jones	Integrated Governance Manager (author)

TB/17/43 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting. Apologies were received as above.

TB/17/44 Declaration of interests (agenda item 2)

There were no declarations over and above those made annually in March 2017 or subsequently.

TB/17/43 Trust Board self-certification – compliance with NHS provider licence conditions

Dawn Stephenson (DS) reported that the Trust was required to self-certify whether or not it has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations supported by the information received throughout the year by the Board and committees including the Integrated Performance Report, Assurance Framework and Risk Register.

It was RESOLVED to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's (now NHS Improvement) Code of Governance and CONFIRM the self-certification declarations in relation to:

- **compliance with the conditions of its Licence (licence conditions G6(3) and CoS7(3));**
- **the Corporate Governance Statement (licence condition FT4(8)); and**
- **the training for Governors (Health and Social Care Act 2012 section 151(5)).**

TB/17/44 Any other business

IB reported that a private session of the Trust Board would be held following the meeting in public which would include the review of the draft Annual Report and accounts for 2016/17. The final versions would be approved by the Audit Committee on 25 May 2017 and would be published once laid before Parliament.

TB/17/45 Date of next meeting (agenda item 3)

The next meeting of Trust Board will be held on Tuesday 27 June 2017 in Rooms 49/50, Folly Hall, Huddersfield.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 23 MAY 2017 – ACTION POINTS ARISING FROM THE MEETING

Actions from 23 May 2017

Min reference	Action	Lead	Timescale	Progress
	There were no actions arising.			

Outstanding actions from 25 April 2017

Min reference	Action	Lead	Timescale	Progress
TB/17/34 Strategic overview of business and associated risks	It was RESOLVED to NOTE the content of the report and that updates would be received every six months.	SY		Complete. Work programme updated.
TB/17/37a Audit Committee annual report 2016/17 (agenda item 8.1), including approval of the Terms of Reference and Work Programme for Trust Board committees	RW commented that he would discuss with IB how any areas for improvement could be incorporated into the Board development programme.	RW/IB		Will be discussed once the new Non-Executive Directors are in place.
TB/17/38 Assurance	The Board discussed that the election may have an impact which was currently unknown. Further	DS/SY	October 2017	

Min reference	Action	Lead	Timescale	Progress
framework and risk register	discussion to be had by the Board after the election, in line with the next strategic overview of business and associated risks report.			
TB/17/41 Trust Board work programme 2017/18	As discussed under agenda item 5, the work programme should be updated to receive the strategic overview of business and associated risks report every six months. As discussed under agenda item 8.4, the work programme should be updated to receive a guardian of safe working hours report every quarter. DS advised that guidance had been received from NHS Improvement for a Trust Board self-certification on compliance with NHS provider licence conditions due for submission at the end of May 2017. The annual item would be added to the work programme. It was RESOLVED to update the work programme.	SY/ABe/DS		Complete. Work programme updated.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 4

Title:	**Chief Executive's Report**
Paper prepared by:	Chief Executive.
Purpose:	To provide the strategic context for the Board conversation.
Mission/values:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper references several of the papers in the public and private parts of the meeting and also external papers and links. It will be supplemented by a verbal update
Execu tive summary:	➢ The June 2017 edition of *The Brief* for all staff has been shared with Board members as **Annex A**. This sets out contextual issues, delivery updates, risks and priorities. Since publication of *The Brief* we have seen: o The outcome of the General Election. o A reiteration from the CEOs of the national NHS Bodies and the Secretary of State that we have a clear path to delivering the Five Year Forward View and should "get on with it" o A renewed focus on the workforce nationally and locally o Further consultation from the CQC on its future role o A new set of local MPs joining established figures (**See Annex B)** o Developments in the South and West Yorkshire Sustainability and Transformation Partnerships that will impact upon the Trust o Successful and unsuccessful bids for specialist services to be devolved to providers o Firming up of Accountable Care developments in Barnsley o A series of listening events for staff and the results of the Robertson Cooper Survey ➢ We have also started the year well in terms of finance and performance building on good performance in 2016/17 **(See Annex C)**. ➢ The issues raised within this paper are adequately reflected in the assurance framework and risk register, with due consideration of the risk appetite, particularly on safety and finance.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017

Chief Executive's Report

Purpose

1. This report sets the context for the Board meeting and comes at a time of significant developments in the country as a whole. It should be **read in conjunction with *The Brief* for June** which is cascaded to all staff and is attached at **Annex A.** This report builds on the content of *The Brief* updating for specific developments of note.

National Context

2. The election brings some clarity following a period of potential political uncertainty about the direction of travel for the NHS. This was exemplified by the presentations at the NHS Confederation Conference on 14th and 15th June 2017. The Conference was the first opportunity for the national leadership of the NHS to engage with senior leaders from across the country.

3. The Secretary of State, CEO of NHS England, CEO of Health Education England and CEO of NHS Improvement set out a number of consistent themes and priorities for the next year. There was a striking shift in one of the dominant narratives to be around the **workforce**. All of the speeches and content can be found on the NHS Confed website (http://www.nhsconfed.org/confed17). In summary we are being asked to **carry on delivering the vision set out in *The Five Year Forward 2 Years On*** (https://www.england.nhs.uk/2017/03/next-steps-on-the-five-year-forward-view/). Board members will recall this had a focus on:

a. Urgent emergency care
b. Mental health
c. Cancer
d. Maternity
e. Primary care and general practice
f. Financial discipline
g. Delivering Accountable Care Systems (ACS) through Sustainability and Transformation Partnerships (STPs)

4. This is a helpful degree of continuity in a difficult and uncertain environment where issues such as Brexit, the Grenfell tower fire and the terrorist attacks in London and Manchester have dominated. The emergency services have rightly gathered plaudits for the work that they have done and their response to tragic events. The NHS has gained even greater support from politicians and public commentators.

5. The Secretary of State suggested that an **early deal on allowing EU residents in the NHS right to stay** was a priority. This is essential, given that new EU registrations have almost completely collapsed. He also said that there would be **no legislative change in the NHS until after Brexit**. Even then this would require cross party support potentially opening the door for cross party work on the future of the NHS.

6. **All of this makes our focus on relationships, joined up care and place within our strategy highly relevant.** The continuing focus on STPs ensures a genuine focus on both national and local priorities.

7. **It also means that a local focus on harnessing the power of communities and coproduction will be essential.** This part of the equation is in danger of becoming lost in a focus on finance and performance. In the last month, I have spoken at the Kings Fund on these topics, highlighting the great work of the Trust and the ambitions of the Sustainability and Transformation Plans (STP) (https://www.kingsfund.org.uk/sites/files/kf/media/Rob_Webster_STPs_social_prescribing.pdf). It was a privilege to see Creative Minds (http://www.southwestyorkshire.nhs.uk/quality-innovation/creative-minds/) and the Wakefield Vanguard (https://connectingcarewakefield.org/) recognised in the meetings and to see the team present to Prince Charles about their work (https://www.kingsfund.org.uk/sites/files/kf/media/Jill%20Poole.pdf)

8. **Health unions have seized upon the workforce issues and written to the Government seeking an end to the 1% pay cap.** This is something that the NHS Confederation are also calling for as part of the need to manage workforce supply, recruitment and retention. The alternative is more industrial unrest and potentially industrial action.

9. **The Care Quality Commission is consulting on the next phase of regulation** (http://www.cqc.org.uk/get-involved/consultations/our-next-phase-regulation-consultation-2). In particular, they are seeking views on proposals to:

    a. regulate **primary medical services** and **adult social care** services
    b. improve the structure of **registration**, and clarify our definition of registered providers
    c. monitor, inspect and rate **new models of care** and large or complex providers
    d. use our **unique knowledge to encourage improvements** in the quality of care in local areas
    e. carry out our role in relation to the **fit and proper persons** requirement.

10. The Trust will respond appropriately, continuing our good relationship with our quality regulator.

Local and Trust context

11. **Following the election we have seen some changes to local MPs. Annex B** sets out a full list of our MPs in this Parliament. I have written to each of them offering support and to make contact with the new MPs and their offices. Their political involvement and political leadership – alongside local councils, will be essential in the coming years.

12. **South Yorkshire STP was named as one of the first 9 Accountable Care Systems following the election.** This may see greater authority delegated to the Sustainability and Transformation Plan (STP) leadership as well as control over some transformation fund resources. In return STP leaders are expected to sign a performance agreement. A draft Memorandum of Understanding (MOU) for the South Yorkshire STP is also included on the Board agenda. The status of the Trust within the MOU is still up for debate.

13. **As part of the delivery of the Five Year Forward View, every STP will be asked to submit a delivery plan on the big clinical priorities of urgent care, cancer, mental health, primary care and maternity.** This has the potential to change the dynamic between STPs and constituent organisations like ours. With STPs asked to take on more of a performance management role. This is counter to a partnership ethos at the heart of the STP. We are working in West Yorkshire to understand how we combat this and preserve the partnership approach. In South Yorkshire this will be determined by the performance agreement and the Memorandum of Understanding (MOU). The first delivery plan for urgent emergency care was submitted on 23rd June 2017.

14. **Our bids to develop improved specialist Child and Adolescent Mental Health (CAMHS), Forensic and Eating Disorder Services in West Yorkshire have been assessed by NHS England.** We have succeeded in our collective bids on CAMHS and Eating Disorders. We were not successful on Forensics. We will now see whether we can continue with local provider led developments on the latter through the STP. The successful bids will see power given to local providers to lead change with the budget delegated from NSH England.

15. **The development of Accountable Care Organisations to support local Health and Wellbeing Strategies continues.** We continue to play a role in delivery of each of these and the Board agenda reflects this. At the same time, commissioners in Barnsley continue with a fairly assertive round of tendering and managed change.

16. **The national messages about the importance of the workforce are mirrored in the work we are doing within the Trust.** The workforce strategy signed off by the Trust in March 2017 has been taken out for testing and priority setting with 4 listening events across the organisation. I have personally led these, with support from Communications and Human Resources teams and input from the directors. The events have been attended by a cross section of staff.

17. They are informed by the results of the Roberston Cooper Wellbeing Survey. This was completed by over 1,800 staff within a 4 week period. The results were available days after the survey closed (in comparison the national survey takes several months to report and has a few hundred responses). The Director of Human Resources, OD and Estates has done another excellent job promoting this work across the organisation. At a high level, it shows that

    - **4 in 10 staff responded:** 1,890 staff responded, 42% response rate.

- **Results have improved and stayed stable:** Results remained typical in most areas since 2016 full survey, and have improved on 2013, 14, & 15 Pulse surveys (which are a direct like for like comparison). In particular, job security and change has improved from red to amber and other areas improved from red and amber to green (typical) for the population.
- **There are a number of areas within the Trust demonstrating negative results** which require a focus on the directorate results
- **Change as a pressure**: "Future job change" is still the most concerning area for staff compared to the external benchmark, and in absolute terms 6 in 10 staff report being troubled by this.

18. **A detailed report from the listening events and the survey will come to the Board in July.** The aim is to ensure that we move from reacting to surveys to using them to inform our strategy. All staff will receive feedback through The Brief and a special Extended Executive Management Team meeting next month. Their feedback will directly inform the priorities within the workforce plan. These will include flexible working, better support for agile working, training, development and delivering improvements in our IT.

19. **IT and Data as enablers were a strong theme, and the Board is discussing the re-procurement of our clinical record system.** Once a decision has been made, we will be handing implementation over to the Director of Strategy and the Director of Nursing and Quality to ensure this is clinically driven with effective change support. Clearly this is a change programme and not an IT programme. We are recruiting a team to support implementation and welcome Ed Reid as Programme Director on secondment from NHS Digital, where he was head of professio, to deliver the technical solutions in support of staff.

20. **During this period of change, we will continue to engage with staff, celebrate success and tackle issues directly.** This is important and I am keen to ensure that we recognise the impact that change has on staff. In my back to the floor sessions I see this constantly. And huge change continues. For example, staff in Pharmacy have worked tirelessly to put in place a new IT system, change our pharmacy drug supply arrangements and their distribution networks. They have done this selflessly and successfully and deserve our thanks.

21. **As part of our communications effort, we have produced summary documents about the Trust and our performance in the last year.** These are attached at **Annex C**.

Conclusion

22. **During this post-election period, we will continue to implement our strategy and the service improvements set out in the STP.** The political context we work in nationally is more fluid and this may play out more significantly in local politics. If we keep our focus on what matters – the delivery of our mission, our plans and the commitment to live our values – we will be successful. In a bleak period for the nation, building realistic and credible plans for the future and reflecting on our recent past brings hope and momentum for the future.

Rob Webster

Chief Executive

1 June 2017

South West Yorkshire Partnership NHS Foundation Trust

The Brief

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 put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent, 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.

What's happening externally?

National and local news

- Political parties published their manifestos ahead of the general election – a variety of commitments about the NHS were made.
- The NHS became the highest-profile victim of a global ransomware attack
- There was speculation surrounding the financial impact of Brexit on the NHS and this will continue to be a focus throughout the upcoming Brexit negotiations.
- The King's Fund published a new mental health report on learning from vanguards. It drew on their research with new models of care sites across England, conducted in partnership with the Royal College of Psychiatrists.

What's happening internally?

Safety and quality

We're implementing our Care Quality Commission (CQC) action plan following publication of our latest report. We have 7 'must do' and 15 'should do' actions to address. We will discuss our action plan with partners at our Quality Summit being held on 13 June.

Our Friends and Family Test results showed that 97% of people recommend our community services, with 85% recommending our mental health services.

We had 807 incidents in Apr, the vast majority of which were low or no harm:

- Green no harm - 490
- Green - 227
- Yellow - 71
- Amber - 14
- Red - 5

We had four serious incidents reported in Apr, and no never events.

Our Quality Accounts for 2016/17 have been signed off - we'll be able to publish them in July. Our Quality Priorities for 2017/18 are based on the CQC domains:

- **Safe** - including fill rates, mortality reviews, suicide prevention, reducing harm, risk assessments, and clinical record keeping
- **Effective** - including care planning, clinical supervision, information governance standards, transitions of care, and skilled workforce

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

- **Caring** - including patient experience, peer support, nursing and allied health profession strategies
- **Responsive** - including access, complaints, and freedom to speak up guardians
- **Well-led** - including quality improvement

Performance (Apr)

- **110%** safer staffing fill rate
- **110%** fill rate of registered nurses - **7** wards fell below our 80% threshold on days, none on nights
- **5%** of appointments weren't outcomed on our clinical systems
- **6** confidentiality breaches - please look after personal details as if they were your own
- **68%** of prone restraints lasted less than 3mins - our target is 80%

We're updating our monthly performance report to reflect changes in the national metrics that we need to submit. We're also making sure it helps us keep track of progress against our 2017/18 strategic priorities.

Staffing

Our April sickness absence rate was down to 4.9%. A new target has been set at 4.5% for 2017/18 (compared to 4.4% last year). This is made up of minimum targets for each area:

- Barnsley: 4.5%
- Calderdale & Kirklees: 4.5%
- Wakefield: 4.6%
- Specialist services: 4.5%
- Forensics: 5.4%
- Support services: 4.0%

In other staffing related developments:

- Our staff wellbeing survey deadline has been extended to 5 June giving even more people the chance to have your say.
- Staff listening events are being hosted throughout June. They're a great opportunity for staff to share their views with our chief executive and directors.
- Our black, Asian and minority ethnic staff network have helped develop a guide for managers on how to support colleagues during Ramadan.

Month 1 finances (Apr)

In April we had a small surplus of £26k in line with our plan - we overspent on out of area placements by £112k and are working to address this

We spent £500k on agency in Apr - our cap for this financial year is £5.7m

We saved £400k in CIPs in Apr, £100k less than we'd planned for - we need to achieve £8.6m of CIPs this year, which will be challenging

We've started the financial year in NHS Improvement's segment 1 (out of 4) for finance, which is the highest score possible

Infrastructure

There are lots of estates developments ongoing, including:

- Contracts have been exchanged on the sale of Castleford, Normanton and District Hospital
- The new wellbeing and learning centre, our central change hub, has been refurbished and is now open to all staff
- The build of our non-secure wards at Fieldhead is progressing well – they'll open later in the year

In terms of our IT infrastructure, we've seen a number of developments:

- We're nearing the end of the procurement process for our mental health clinical system,
- IT clinics running from June to October
- Blackberry's are being upgraded with new Samsung smartphones

Change and innovation

- A new change framework was approved at Trust Board on 23 May – it covers large programmes as well as things you can just get on and do
- New Barnsley diabetes single point of access, which offers a more streamlined service for people with the condition in the district, went live from 1 June
- Intermediate care changes progressing and clinical lead role has been advertised
- The Mental Health Museum was showcased on BBC Look North

Congratulations to three of our teams on their award successes:

- Smokefree Sheffield - shortlisted in the HSJ Value awards
- Kirklees police liaison service - won West Yorkshire Police award for 'solving problems with partners'
- Staff involved in the Dementia Friendly Lindley event won the Huddersfield Examiner community award

South West Yorkshire Partnership NHS Foundation Trust

Focus on:

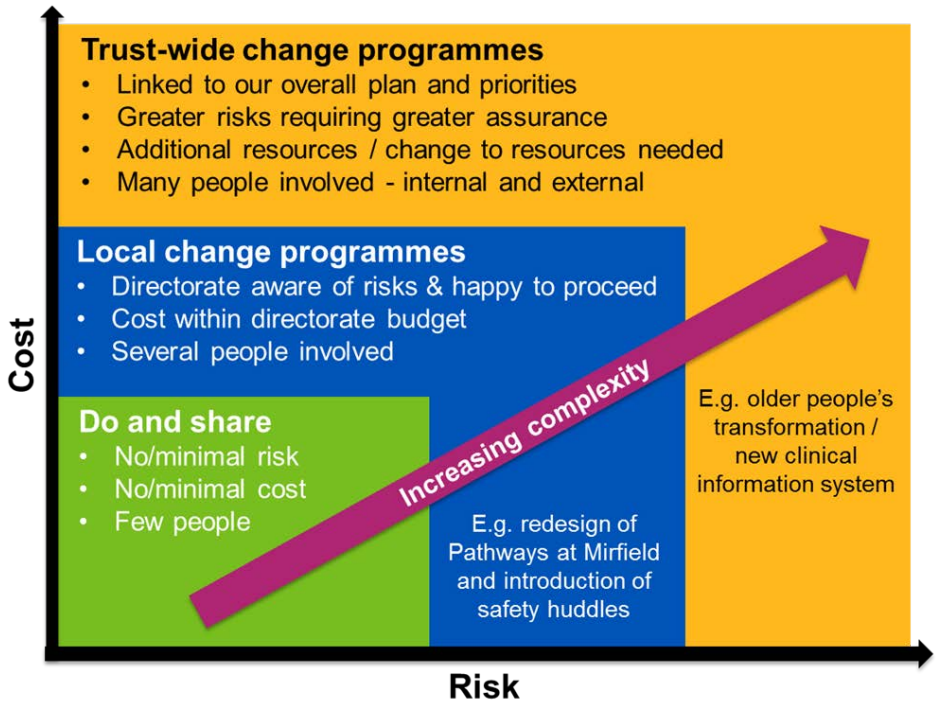
Our 2017/18 priorities

We've agreed six priority areas that we need to focus on for the coming year, which align to our three strategic objectives:

Improving health	Improving care	Improving resources
1 People at the centre ▪ Enhancing liaison services ▪ Improving people's experience ▪ Recovery based approaches ▪ Physical / mental health	**3 Quality counts, safety first** ▪ Patient safety ▪ Older people's transformation ▪ Improving autism and ADHD ▪ Perinatal mental health ▪ West Yorkshire work - CAMHS, forensics, suicide prevention ▪ Quality priorities	**5 Operational excellence** ▪ Flow and out of area beds ▪ Workforce - sickness, rostering, skill-mix and agency ▪ Effective use of supplies and resources ▪ CQUIN ▪ Financial sustainability and CIP
2 Joined-up care ▪ Supporting place-based plans ▪ Accountable care in Barnsley and Wakefield ▪ New models of care and vanguards	**4 Compassionate leadership** ▪ Leadership development ▪ Change and quality improvement ▪ Membership	**6 Digital by default** ▪ Clinical record system ▪ Digital health ▪ Data driven improvements and innovation

Our approach to change

Our new approach to change for the coming year is a simple one based on cost, risk and complexity. It will reduce bureaucracy and supports decision making closest to our services/service users, while providing appropriate support and governance for big Trust-wide changes.



With **all of us** in mind.

1 June 2017

South West Yorkshire Partnership NHS Foundation Trust

Take home messages

1. There's lots happening externally - let's focus on what we can control and influence
2. Safety first, always - we need to deliver our CQC action plan and 17/18 Quality Priorities
3. This year will be challenging and we need to make £8.6m savings
4. Our new approach to change will help - there's lots you can do and share with colleagues
5. It's important we stay resilient and look after ourselves and each other
6. Continue to help shape your Trust - complete your wellbeing survey and attend a listening event

With **all of us** in mind.

Election 2017 results

Constituency: Calder Valley
MP: Craig Whittaker
Party: Conservative (hold)
Voting result: 46.1% (Josh Fenton Glynn Labour 45.1%)

Constituency: Colne Valley
MP: Thelma Walker
Party: Labour (gain)
Voting result: 47.7% (Jason McCartney Conservative 46.2%)

Constituency: Halifax
MP: Holly Lynch
Party: Labour (hold)
Voting result: 52.8%

Constituency: Huddersfield
MP: Barry Sheerman
Party: Labour (hold)
Voting result: 60.4%

Constituency: Dewsbury
MP: Paula Sherriff
Party: Labour (hold)
Voting result: 51.0%

Constituency: Batley and Spen
MP: Tracy Brabin
Party: Labour (hold)
Voting result: 55.5%

Constituency: Wakefield
MP: Mary Creagh
Party: Labour (hold)
Voting result: 49.7% (Antony Calvert Conservative 45.0%)

Constituency: Hemsworth
MP: Jon Trickett
Party: Labour (hold)
Voting result: 56%

Constituency: Barnsley Central
MP: Dan Jarvis
Party: Labour (hold)
Voting result: 63.9%

Constituency: Barnsley East
MP: Stephanie Peacock
Party: Labour (hold)
Voting result: 59.5%

Constituency: Penistone & Stocksbridge
MP: Angela Smith
Party: Labour (hold)
Voting result: 45.8% (Nicola Wilson Conservative 43.2%)

Constituency: Normanton, Pontefract % Castleford
MP: Yvette Cooper
Party: Labour (hold)
Voting result: 59.5%

Constituency: Morley & Outwood
MP: Andrea Jenkyns
Party: Conservative (hold)
Voting result: 50.7%

NB. Second voting result only given if close to winner

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Our year

What we achieved in 2016/2017

With **all of us** in mind.


Leader of the year, Dr Subha Thiyagesh


Outstanding achievement, Debs Taylor


Rising star, Trevor Jones


Unsung hero, Laura Habib

Why we're here

Our mission is very important to us. It's why we're here:

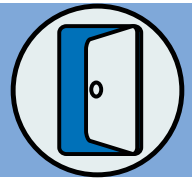
We exist to help people reach their potential and live well in their community.

Our vision is to provide outstanding physical, mental and social care in a modern health and care system

Our values are lived by our staff every day. They guide all that we do:

We put people first and in the centre and know that families and carers matter

We are respectful, honest, open and transparent



We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

Last year, there were many examples of how we meet our mission and live our values. We showcased the best at our Excellence 2016 awards. Our individual award winners are shown opposite.

We improved care and were re-rated as ‘Good’

In June 2016 the Care Quality Commission (CQC) rated us as ‘Requires Improvement’.

Less than six months later, they came to see us again and saw we had improved. In the spring of 2017 they changed our rating to ‘Good’.

2016

2017

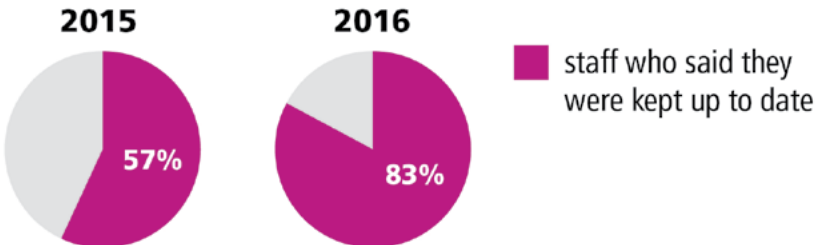
90% of the domains in our service lines were ‘Good’ or ‘Outstanding’.

In particular the CQC saw that:

- There had been a positive change in our culture
- All staff were kind, caring and compassionate – as well as respectful and warm
- We personalised care plans and looked at the whole person. There was also good evidence of patient involvement and participation.

We became a better place to work and improved in staff surveys

- We introduced new band 2 and band 4 roles, creating a better career path for our staff
- Our senior leaders are more visible across the organisation
- We improved communication and engagement with our staff

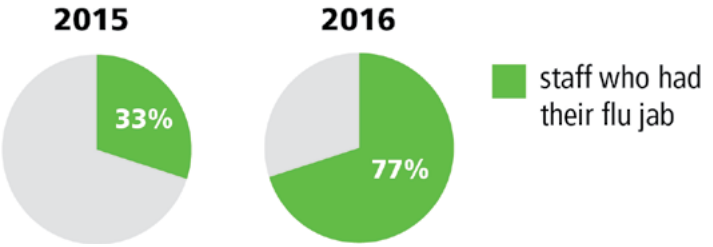


- Our 2016 NHS Staff Survey results showed we had improved the fairness and effectiveness of how incidents are reported. Communication with senior management was also better.
- At the end of March 2017, we had 206 volunteers – representing a fantastic contribution of 773 hours per week - that's 37808 hours over the year. Our volunteers enhanced services by undertaking a wide variety of roles, for example on our wards, in catering, estates, health records, and in befriending, expert patient and spirit in mind services.

We came together…when it really mattered

We came together…
when we needed to focus on a particular issue.

For example, we met our flu vaccination target.



This put us in the top 5 most improved Trusts across the country.

We came together…
in the face of adversity.

For example, when we had a serious fire on our Trinity 2 ward in Wakefield.

> *"The Trust, staff teams and all the support services had worked together to ensure that the service continued with minimum disruption in a challenging new environment."*
>
> ***Care Quality Commission***

We came together…
to deal with the unexpected.

For example, when there was an increase in how many people had to go out of our area for care.

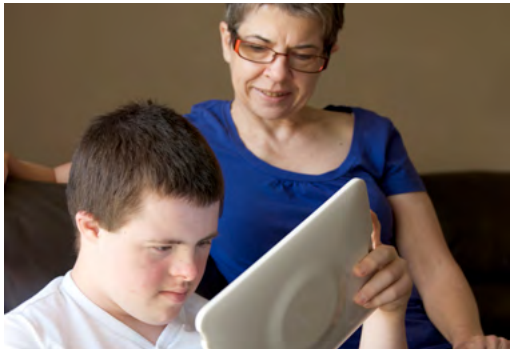
We worked across our mental health services to make improvements. This reduced how many people had to go out of our area.




Our three strategic objectives for 2016/17 were:

1. Improve people's health and wellbeing
2. Improve the quality and experience of all that we do
3. Improve our use of resources

Thank you to our staff, people who use our services, carers, families, members and partners. Our achievements were only possible because we worked together.




We got ready for tomorrow with major developments

- We developed new hubs in the heart of our communities, including Drury Lane and Baghill House health and wellbeing centres

Drury Lane

Baghill House

- We started building new mental health wards at Fieldhead in Wakefield. This is an investment of over £17 million

Fieldhead Hospital

£17+ million

- We launched a virtual hub, i-hub, to share ideas
- More than 2,000 new laptops are now in use
- Lots of our staff are working in an agile way – this gives people maximum flexibility and minimum barriers
- We piloted new smartphones to replace our old Blackberrys.

We won bids and tenders and worked in partnership

£2.8m
Kirklees CAMHS
as part of wider children's healthcare contract with Locala

£1.2m
Calderdale CAMHS
rolled over

£2.1m contract from NHS England
£17k for training from Yorkshire and Humber Clinical Networks
Perinatal community mental health

£1.9m from NHS England
Calderdale and Kirklees
integrated IAPT

£420k
Wakefield social wellbeing service
with Nova

£279k from NHS England
Mental health liaison funding
across Calderdale, Kirklees, Wakefield, Dewsbury and Pontefract

£100k
Wetherby Young Offender Institute
psychologically informed environments funding from NHS England

Liaison alliance coordinator funding for
South Yorkshire liaison services

We won awards and showcased our work

Many of our excellent services, staff and initiatives were recognised. Here's a snapshot!

Awards

- Our forensic women's service won a Yorkshire and Humber Academic Health Science Network improvement award
- RightCare Barnsley won a Health Service Journal award
- Our police liaison service won a commendation from West Yorkshire Police
- Laura Mitchell and Baghill House health and wellbeing centres both won awards for their innovative design and development
- Our new visual identity won an Association of Healthcare Communications and Marketing award
- Katie Yockney, practice educator in our end of life care team won the palliative care award in the regional Great British Care Awards
- Sheffield Smokefree were shortlisted in the HSJ Value in Healthcare awards
- Kirklees recovery college was given the Kirklees Volunteering Quality Award

Endorsements

- Our autism friendly environments checklist was endorsed by the National Institute for Health and Care Excellence (NICE)
- Our Mental Health Museum was made an affiliate of The Happy Museum scheme, funded by Arts Council England
- We were re-accredited against the Government's customer service excellence (CSE) standard for the fourth year in a row
- Calderdale and Wakefield (Briarfields) ECT (electroconvulsive therapy) units achieved national accreditation for the 8th consecutive year
- We celebrated national volunteering week by being accredited against the Investing in Volunteers Standard – a UK recognised standard that evidences best practice in recruitment, placement and ongoing support for people who give their time to volunteer

Sharing best practice

- Our Barnsley Integrated Community Equipment Service was highlighted on BBC's The One Show
- We ran a sell-out conference on harmful sexual behaviour in young people
- We showcased Creative Minds at the Health and Care Innovation Expo, and as part of the national Realising the Value programme.
- Our Portrait of a Life training resources are part of the Wakefield Connecting Care Home Vanguard. Our work was shared on BBC Radio 4, as part of NHS England's Vanguards good practice and described by global health care quality guru, Professor Don Berwick, as 'mind blowing'
- Our forensic CAMHS service shared their knowledge and expertise at an international conference in Portugal

We faced great challenges and remained resilient

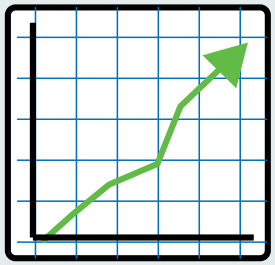
2016/17 was a challenging year. Above all, we remained resilient in our response. Key challenges that emerged during the year included:

Out of area placements

The number of people who had to leave our geographical area increased unexpectedly. This meant we overspent by more than £2m.

Agency spend

Sometimes we need to use staff from agencies. NHS Improvement set a limit on how much we should spend on this. We spent 90% more than the limit we were set.



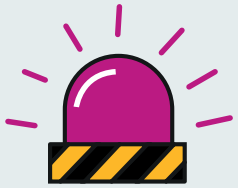
Increased demand

on our services and increased acuity. Acuity is a way of measuring how unwell somebody is - how dependent they are on staff and what support they will need. This helps us make sure we have the right levels of staff to care for people in the right way.

Decommissioning of services

Some of our services were no longer funded to be run by us, eg Kirklees stop smoking service.

Serious incidents



These are always something we deeply regret, and we make sure we learn from.

We all played our part and achieved our financial plan

What money did we get?

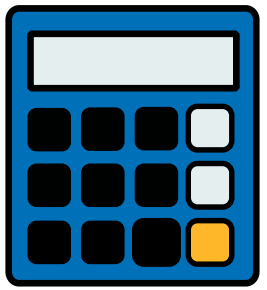
- Our income (money coming in) in 2016/17 was **£229.9m**
- **93%** of our income came from clinical commissioning groups (CCGs), NHS England, Local Authorities and other NHS bodies
- Other money comes from things like education and training and research and development.

How did we do?

- Most of our income is a fixed payment. However, **2.5%** (£4.5 million) was based on us meeting targets and key quality indicators – known as CQUINs. We achieved **86%** of these.
- We exceeded our **£500k** financial plan / control total by **£250k**. This control total was agreed with NHS Improvement.
- Achieving it was very important; as it secured **additional £1m income** from the Sustainability and Transformation Fund

During the year

- We had a fire in Wakefield on one of our mental health wards and received an insurance payment for this
- We saved **£1.2m** across our support services
- We reduced how much we spent on non-essentials (our discretionary spend)
- We started to turn around how much we spend on out of area care



Our 2016/17 annual report and accounts will be published on our website:

www.southwestyorkshire.nhs.uk

@allofusinmind

Job No. 0212 May 17

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 5.1

Title:	**Integrated Performance Report Month 2 2017/18**
Paper prepared by:	Director of Finance and Director of Nursing & Quality
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for May, 2017.
Mission/values/objectives	All Trust objectives.
Any background papers/ previously considered by:	Not applicable.
Executive summary:	➢ The Integrated Performance Report (IPR) has been updated this month to include updates in national metrics and targets ➢ A summary of key metrics summarising performance against the Trust objectives has been included in this month's report. A number of these are being developed, whilst some are quarterly metrics ➢ A section has been added to capture progress against Trust priority programmes. This will develop over the next couple of months as further progress is made on scoping and defining some of the programmes. Senior Responsible Officers have been identified for all programmes. **Quality** ➢ Five serious incidents reported in May, three of which were suicide or apparent suicide ➢ Overall fill rates for majority of Trust inpatient areas remain above 90% for registered staff. Trustwide average fill rate of 111% ➢ CQC quality summit took place on 13 June 2017 ➢ One confirmed case of C.difficile during Quarter 1 ➢ Within Friends & Family tests 99% recommend community services and 82% mental health services ➢ Quarter 4 2016/17 CQUIN is close to finalisation. Final settlement likely to be in line with forecast ➢ No Information Governance breaches reportable to the Information Commissioners Office (ICO) in the month **NHSI Indicators** ➢ Continued under-performance in IAPT for clients moving to recovery. Focus on data quality and type of referrals **Finance** ➢ Pre STF surplus of marginally above break-even in May (£27k) ➢ Cumulative pre STF surplus of £53k ➢ Out of area beds overspend of £164k in the month (£277k cumulatively) was offset by £0.3m pay savings driven by an improved agency position (actual spend of £0.4m in month). The other notable overspend relates to drugs costs (£60k) ➢ Use of resources risk rating of 1 given the improved agency position ➢ CIP delivery of £1m is £50k below plan. £0.2m has been delivered non-

	recurrently ➢ Cash balance of £21.5m is significantly below plan due to timing of STF receipts and timing of other receipts. **Workforce** ➢ Sickness absence in May improved to 4.8% ➢ Safer staffing summit took place with a wide range of staff involved ➢ Steady increase in mental Health Act and Mental Capacity Act training, but still short of the 80% target. ➢ Majority of mandatory training above 80% target. Focus being applied to those below target
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

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Integrated Performance Report

Strategic Overview

May 2017

With **all of us** in mind.

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report for May 2017. The recent developments on the report now ensure that an owner has been identified for each key metric, and the alignment of the metrics with Trust objectives and CQC domains. This ensures there is appropriate accountability for the delivery of all our performance metrics and helps identify how achievement of our objectives is being measured. The report is now more in line with the vision of having a single report that plots a clear line between our objectives, priorities and activities. The intention is continue to develop the report such that it can showcase the breadth of the organisation and its achievements as well as meeting the requirements of our regulators and providing an early indication of any potential hotspots and how these can be mitigated. Following discussion at the Trust Board Development session a number of amendments have been included in the report this month. An executive summary of performance against key measures has been included which identify how well the Trust is performing in achieving its objectives. A new section has been added into the report which outlines the progress the Trust is making against its agreed priority programmes. This particular section will develop over the next few months in line with the development of plans behind each priority. It should be noted this section excludes those priority programmes which are already reported on elsewhere in the report e.g. quality, finance. In addition where there are newly identified national metrics and targets these have been included in the report
It is recognised that for future development stronger focus on outcomes is required and a clearer approach to monitoring progress against Trust objectives would be beneficial.

The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports that the board receives.

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

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
- Strategic Summary
- Quality
- National metrics (NHS Improvement, Mental Health Five Year Forward View, NHS Standard Contract National Quality Standards)
- Locality
- Transformation
- Priority Programmes
- Finance
- Contracts
- Workforce

Performance reports are available as electronic documents on the Trust's intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

Section	KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Forecast
Single Oversight Framework metric		2	2	2											2
CQC Quality Regulations (compliance breach)		Green	Green	Green											Green

Improve people's health and reduce inequalities	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Forecast
Total number of children & young people in adult inpatient wards	0	0	1											1
% service users followed up within 7 days of discharge	95%	98.3%												1
% clients in settled accommodation	TBD	Data Not avail 1												
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks		Data avail end of Q1.												
Out of area beds 2	<=100 Green 101 - 199 Amber >=200 Red	281	348											
IAPT –proportion of people completing treatment and moving to recovery	50%	45.6%	49.4%											

Improve the quality and experience of care	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Forecast
Friends and Family Test - Mental Health	85%	85%	82%											85%
Friends and Family Test - Community	98%	97%	99%											98%
Patient safety incidents involving moderate or severe harm or death		20	28											
Safer staff fill rates	90%	110%	111%											100%
Number of records with up-to-date risk assessment (MH)		KPI under development												
IG confidentiality breaches	<=8 Green 9 -10 Amber	9	12											
% people dying in a place of their choosing		KPI under development												

Improve the use of resources	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Forecast
CQUIN achievement	£803k	£346k	£664k											£4185k
Surplus vs Control Total	In line with Plan	£26k	£53k											£1020k
Agency spend	In line with Plan	£501k	£426k											£5662k
CIP delivery	£1074k	£472k	£1024k											£8262k
Sickness absence	4.5%	4.90%	4.80%											4.50%
Mental Health Act training	>=80%	51.2%	56.9%											80%
Mental Capacity Act Training	>=80%	64.9%	69.6%											80%

NHSI Ratings Key:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Notes:
1 - There was no April Primary submission this month due to the transition to MHSDS v2. Data to flow monthly from May 17 onwards.
2 - Out of area beds - this identifies the number of out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for Adult Acute and PICU Mental Health Services only.

Lead Director:

• This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
• A number of targets and metrics are currently being developed and some reported quarterly.
• More detail on areas of underperformance are included in the relevant section of the IPR.

The performance information above shows the performance rating metrics for the new Single Oversight Framework which captures Trust performance against quality, finance, operational metrics, strategy and leadership under one single overall rating. The most significant reasons for the Trust to be rated as 2 were the CQC rating of 'requires improvement' and the level of spend above our agency staff expenditure ceiling. An assessment of the impact of the good CQC rating on our Single Oversight Framework metric has yet to be made. Agency spend is currently below our ceiling.

Areas to Note:

Finance

• Pre STF surplus of marginally above break-even in May (£27k)
• Cumulative pre STF surplus of £53k
• Out of area beds overspend of £164k in the month (£277k cumulatively) was offset by £0.3m pay savings driven by an improved agency position (actual spend of £0.4m in month). The other notable overspend relates to drugs costs (£60k)
• Use of resources risk rating of 1 given the improved agency position
• CIP delivery of £1m is £50k below plan. £0.2m has been delivered non-recurrently
• Cash balance of £21.5m is significantly below plan due to timing of STF receipts and timing of other receipts
• Full year-end review of year-end forecast and risks & opportunities will be carried out in time for the July Board report

Quality

• Five serious incidents reported in May, 3 of which were suicide or apparent suicide
• Overall fill rates for majority of Trust inpatient areas remain above 90% for registered staff. Trustwide average fill rate of 111%.
• CQC quality summit took place on June 13th 2017
• 1 confirmed case of C.difficile during Q1
• Within friends and family tests, 99% recommend community services and 82% mental health services
• Q4 16/17 CQUIN is close to finalisation. Final settlement likely to be in line with forecast
• No Information Governance breaches reportable to the ICO in month

NHSI

• Continued under performance in IAPT for clients moving to recovery.

Workforce

• Safer staffing summit took place at the beginning of June with a wide range of staff involved.
• The Trust sickness rate at the end of May was 4.9% which is slightly higher than the same time last year (4.6%). Reduction in sickness is part of the Trust's Operational Excellence Programme and is included in General Managers and Clinical Leads objectives. A task group on reducing sickness has been established following the staffing summit.
• Appraisal target is 95% of band 6 appraised by end of quarter 1 and this will be reported at the end of July.
• Clinical Risk training target has been reprioritised to allow a focus on staff release for Mental Health Act and Mental Capacity Act Training.

Quality Headlines

Work has been undertaken to identify additional quality metrics, some of these are under development and are likely to be in place by the end of quarter 1. For the new indicators where historic data is available, this has been included. These indicators can be used to measure progress against some of the Trusts quality priorities for 2017-18.

Section	KPI	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Year End Forecast Position *
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Quality & Experience	Safe	TB	6	0	0	1	2	1	0	4
C-Diff	C Diff avoidable cases	Quality & Experience	Safe	TB	0	0	0	0	0			4
Complaints	% of feedback with staff attitude as an issue	Quality & Experience	Caring	DS	< 20%	14% 23/168	7% 12/162	18% 28/158	12% 23/195	20% 13/63	14% 11/77	4
Service User Experience	Friends and Family Test - Mental Health	Quality & Experience	Caring	DS	85%	72%	71%	71%	79%	85%	82%	2
	Friends and Family Test - Community	Quality & Experience	Caring	DS	98%	98%	98%	98%	99%	97%	99%	4
Quality	Total number of reported incidents	Quality and Experience	Safety Domain	TB	N/A	3509	3405	3293	2946	838	983	N/A
	Total number of patient safety incidents resulting in severe harm and death	Quality and Experience	Safety Domain	TB	N/A	10	19	19	20	4	5	N/A
	Total number of patient safety incidents resulting in moderate or severe harm and death	Quality and Experience	Safety Domain	TB	N/A	73	79	73	84	20	28	N/A
	MH Safety thermometer - Medicine Omissions	Quality and Experience	Safety Domain	TB	17.7%	16.80%	17.70%	Data not avail				3
	Safer staff fill rates	Quality and Experience	Safety Domain	TB	90%					110%	111%	4
	Safer Staffing % Fill Rate Registered Nurses	Quality and Experience	Safety Domain	TB	80%					109.7%	109.7%	4
	Number of pressure ulcers (attributable) 1	Quality and Experience	Safety Domain	TB	N/A	98	95	78	86			N/A
	Number of pressure ulcers (avoidable) 2	Quality and Experience	Safety Domain	TB	0	1	4	3	2	0		3
	Complaints closed within 40 days	Quality and Experience	Responsive	DS	80%				28% 11/39	10% 2/20	24% 6/24	1
	Referral to treatment times	Health & Wellbeing	Responsive	KT/SR/CH	TBC	KPI under development						
	Un-outcomed appointments 6	Quality and Experience	Effective	KT/SR/CH	TBC		2.2%	2.9%	2.6%	5.0%	4.6%	
	Data completeness	Quality and Experience	Effective	KT/SR/CH	TBC	KPI under development						
	Number of unvalidated records	Quality and Experience	Effective	KT/SR/CH	<10%	KPI under development						
	Number of Information Governance breaches 3, 5	Quality and Experience	Effective	MB	<=8	36	25	29	36	9	12	
	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Quality and Experience	Caring	AD	80%	N/A	79.26%	N/A	80%	N/A		N/A
	Staff FFT survey - % staff recommending the Trust as a place to work	Quality and Experience	Caring	AD	N/A	N/A	65.19%	N/A	66%	N/A		N/A
	Number of compliments received	Quality and Experience	Caring	DS	N/A	Data not avail until Oct 16.		141	81	19	44	N/A
	Eliminating Mixed Sex Accommodation Breaches	Quality and Experience	Safety Domain	TB	0	0	0	0	0	0	0	4
	Number of Duty of Candour applicable incidents 4	Quality and Experience	Caring	TB	N/A	73	86	83	86	21	25	N/A
	Duty of Candour - Number of Stage One exceptions 4	Quality and Experience	Caring	TB	N/A	Reporting established from Oct 16		0	2	1	0	N/A
	Duty of Candour - Number of Stage One breaches 4	Quality and Experience	Caring	TB	0	Reporting established from Oct 16		0	1	0	0	
	% Service users on CPA given or offered a copy of their care plan	Quality and Experience	Caring	KT/SR/CH	80%	85.6%	85.0%	83.0%	85.2%	85.2%	85.0%	4
	% of prone restraint with duration of 3 minutes or less	Quality and Experience	Safety Domain	KT/SR/CH	80%	Reporting Established from July 16	79.7%	75.6%	66.3%	68.40%	75.70%	4
	Delayed Transfers of Care	Quality and Experience	Effective	KT/SR/CH	8%	2.2%	2.6%	3.1%	2.7%	1.9%	1.7%	4
	Number of records with up to date risk assessment	Quality and Experience	Effective	KT/SR/CH	TBC				KPI under development			
	No of staff receiving supervision within policy guidance	Quality and Experience	Well Led	KT/SR/CH	TBC				KPI under development			
	Number of Falls (inpatients)	Quality and Experience	Safety Domain	TB	TBC	162	158	136	95	38	54	
	Number of restraint incidents	Quality and Experience	Safety Domain	TB	TBC					104	140	

** See key included in glossary*

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

3 - The IG breach target is based on a year on year reduction of the number of breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches.

4 - These incidents are those where Duty of Candour is applicable, however some may be subject to confirmation. Data correct at 13/6/17.

5 - The April 17 figure was reported as 6 in the May report. This has subsequently increased to 9 due to a further 3 incidents being confirmed as breaching during April 17.

6 - this is the year to date position for mental health direct unoutcomed appointments which is a snap shot position at a given point in time. The increase in unoutcomed appointments in April 17 is due to the report only including at 1 months worth of data.

Quality Headlines

During 2016/17, the Trust undertook some work to develop the key quality measures. There are a few areas remaining that require additional development; these relate to:
• Referral to Treatment waiting times - we are awaiting some national guidance on this - this was anticipated to be received during November but remains outstanding. This will relate to CAMHs services. We will align our reporting to this once the report criteria is published.
• Data completeness - this indicator is being developed and will focus on the completeness of the clinical record.
As part of the Trust's ongoing review of quality, additional metrics have been identified for reporting in 2017/18 relating to:
• Number of unvalidated records – this metric will allow the Trust to track improvement required within the data quality plan. It is proposed that the threshold with be less than 10%.
• Number of records with up to date risk assessment - the target for this metric is to be agreed in line with CQUIN discussion, to be resolved by mid June. This metric will also allow the Trust to track improvement required within data quality plan.
• No of staff receiving supervision within policy guidance – This metric will allows the Trust to track improvement required within CQC action plan. The threshold is to be set by BDU.
NHS Safety Thermometer - Medicines Omissions – this is an indicator within the CQUINs for the west and has been identified as at risk of achievement. Data remains unavailable due to problems with national software system, however work continues to improve the position and has been positively reviewed by commissioners.

Additional items to note from the dashboard for May 17:
• Number of Falls (inpatients) - April 17 figure has been revised from 39 to 38 due to the recatagorisation of an incident in Forensic services.
• Number of Falls (inpatients) – increase to 54 in May 17 from 38 in April 17. Increase in incidence on Ward 18 in Kirklees which is attributed to 4 multiple falls, with one service user falling 6 times and another falling 4 times in the month.

Falls reduction
In 2014, the Trust joined the national Sign up to Safety campaign, and made five pledges to improve patient safety. The pledges are being addressed through the Patient Safety Strategy implementation plan. The Trust committed to reduce avoidable harm by 2018 in five main areas, including falls. The targets for falls are to 1) reduce the frequency of falls by inpatients by 15% by 2018, and 2) reduce the frequency of inpatient falls resulting in moderate/severe harm or death by 10% by 2018.
The total number of inpatient falls fell from 823 in 2014 to 623 in 2016 with a reduction in falls causing moderate or severe harm from 19 in 2014 to 18 by 2016 with a forecast for a further reduction in 2017. The Trust remains on track to achieve the sign up to safety targets for falls by 2018.

Safety First

Summary of incidents during Q4 16/17 May 17

Summary of Incidents	Q4 16/17	Apr-17	May-17
Green no harm	1803	521	573
Green	731	227	286
Yellow	235	71	92
Amber	71	14	22
Red (should not be compared with SIs)	14	5	10
Total	**2854**	**838**	**983**

• All serious incidents are investigated using Root Cause and Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
• Incident reporting levels remain within the normal range.
• Risk panel remains in operation and scans for themes that require further investigation. Monthly report for Operational Management Group now in place.

No never events reported in May.

Mortality – Trust processes to improve data for deaths reported on Datix is in place from 1/4/17. Monthly meetings are in place to review mortality. Work continues regionally with Mazars to improve mortality reporting and review arrangements. An internal action plan is in place in response to national guidance on learning from deaths issued in March 2017.

Summary of Serious Incidents	Q4 16/17	Apr-17	May-17
Death - cause of death unknown/ unexplained/ awaiting confirmation	2	0	0
causes	1	0	0
Death - confirmed related to substance misuse (drug and/or alcohol)	0	1	0
Fire / Fire alarm related incidents	0	0	0
Formal patient absent without leave	0	0	0
Illegal Acts	0	1	0
(including assault)	0	0	0
behaviour (not against person) by patient	0	0	0
Information disclosed in error	6	0	1
Lost or stolen paperwork	1	0	0
Patient healthcare record issues	1	0	0
against other by patient	1	0	0
against patient by patient	0	0	0
Self harm (actual harm)	0	0	1
intent	1	0	0
Slip, trip or fall - patient	0	0	0
Suicide (incl apparent) - community team care - current episode	3	2	3
team care - discharged	1	0	0
current episode	3	0	0
discharged	1	0	0
Pressure Ulcer - grade 3	3	0	0
Total	**24**	**4**	**5**

Quality Headlines

Safer Staffing

Trustwide average fill rate: 111%

Overall average fill rate for registered staff was 109.7% (- 0.3)

Fill Rates for inpatient areas Nov 2016 – May 2017

Overall fill rates for the majority of Trust inpatient areas remain above 90% for Registered Staff on both days and nights.

Overall

Safer Staffing average Fill across all BDUs were RN days 91.1% (+ 1%), RN nights 101.9% (+ 1.9%) NRN days 126.2% (+ 2.7%) NRN nights 125.3 (- 0.3%).
Overall average fill rate for registered staff was 109.7 (- 0.3)
Average Fill Rates for Barnsley BDU have again increased 4% in May (113%) and in Wakefield reduced by 2% (115%) after both increasing in April by 4 and 5% respectively. Calderdale and Kirklees have increased by 2% (103%) after a 2% drop in April. The Forensic BDU fill rate has increased by 1% (110%) after a 8% decrease in April. Specialist services have decreased by 1% (179%) after a significant increase to 180% in April.

Chippendale ward fell below a 90% (88.3% down 2.6%) overall fill rate in the period of March 2017. This was attributed to, supporting other wards within the BDU. Appleton rose above the 90% threshold after falling below the previous month (92.4% rising 7.5%). Of the remaining 29 inpatient areas 22 (75.8%) achieved greater than 100%.

Where staffing falls below the escalation thresholds, safe services were maintained utilising the professional guidance tool.

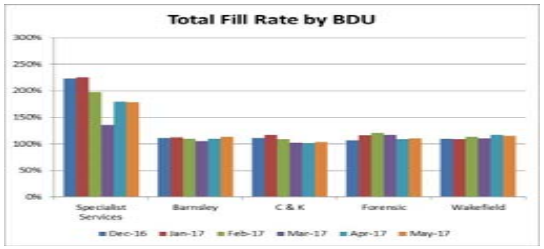
Registered On Days

The number of wards which are achieving 100% and above fill rate has remained at 10% (3 wards) in May, with again 21% (7) achieving less than the 80% threshold. These remain mainly focused in the Forensic BDU (Medium Secure Unit) with Appleton, Chippendale, Hepworth, Priestley and the Women's service being affected. Almost all have increased on the previous month with Chippendale being the only ward with a significant reduction (down 5.1%) again citing the reasons as covering other areas and vacancies among the reasons. Vacancies, maternity and sickness being listed as the main reasons for by the other areas within Forensic. Similar reasons have been given for ward 19 (0.7% increase) , Melton Suite (5.8% decrease) and Willow ward (11.4% decrease). All other wards achieving 80% or above fill rate.

Registered On Nights

The number of wards which are achieving 100% and above fill rate on nights remains consistently above 63%. No wards fell below the 80%.

BDU	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Specialist Services	222%	225%	197%	136%	180%	179%
Barnsley	111%	112%	110%	105%	109%	113%
C & K	111%	117%	108%	103%	101%	103%
Forensic	107%	116%	120%	117%	109%	110%
Wakefield	109%	109%	113%	111%	117%	115%
Grand Total	**112%**	**116%**	**115%**	**110%**	**110%**	**111%**



Annual Report for Incidents

The 2016/17 annual report for incidents has been completed. This was presented to the clinical governance and safety committee on the 13th June 2017.
This report provides an overview of all the incidents reported in the Trust during 2016/17. It also includes further analysis of Serious Incidents, and brief analysis of recommendations arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2016 to 31 March 2017. It also contains an overview of the national developments related to patient safety that have occurred through the year and summary of the work undertaken by the Patient Safety Support Team.

Quality Headlines

Safeguarding

• Safeguarding Adults have organised additional training 'Scams and Rogue Traders, identifying victims and what can be done' following the Kirklees Network Event. This training has been offered to Older People's services in Kirklees and additional sessions are planned for the Recovery College and during the Safeguarding Week in October 2017. Staff have reported that the training is excellent and provides them with the skills and knowledge of what actions and support are available to vulnerable adults.

• At the Wakefield Quality Intelligence Group a discussion was held about the gathering of information in order to protect adults from abuse or neglect via the completion of a Quality Intelligence Notification (QIN) form. The process has been shared with the Practice Governance Coach to disseminate the information and the safeguarding team will attend team meetings/ BDU governance meeting to provide further support to staff.

• The process of gathering data for safeguarding children training has been requested by Calderdale Safeguarding Children Board and has been developed into 'best practice guidance' for partner agencies to use.

• The safeguarding children team have been actively involved with the 'mock' JTAI neglect audits across three locality areas. Areas of learning and themes have been identified and have been shared across teams via the BDU Governance meetings and team meetings. Additionally to raise the awareness of the impact of neglect on children an email was sent to the Deputy Directors, Trio's for further dissemination of the information to frontline staff.

• The notification of the new systemised collection of quarterly Prevent Data utilising the UNIFY 2 system was received into South West Yorkshire Partnership NHS Foundation Trust via a number of routes; NHS England Prevent Lead, NHS England Prevent Support Officer and Trust Performance team. The Trust was identified as a pilot area for the new data collection and our Named Nurse safeguarding Children and Prevent Lead completed the template (using quarter 4's data as requested). The data was uploaded via the performance team and no problems were identified.

Safer Staffing Summit

A staffing summit was held on 7th June 2017 in Barnsley. This was an all-day event which was oversubscribed and had representatives of all Directorates, i.e. Finance, Nursing, HR, Health and wellbeing, safer staffing etc., as well as a large operational representation including directors, deputy directors, general manager of all the BDUs among others. This was led by Karen Taylor (District Director)
There were key presentations from Safer Staffing, Agency, Band 2-4 work stream, finance and workforce performance.
All initiatives throughout the trust to address the ongoing staffing challenges. This included the master vendor, increasing the bank resources, accelerating the process of leaver and returns, bank enhancements, overseas recruitment, engagement with universities.
The summit also considered new approaches and an action plan was developed.

CQC Re-inspection Quality Summit

We held our Quality Summit on the 13th June 2017 to consider the outcome of the revisit and facilitate the co-production of our action plan for continuous improvement. Kate Gorse-Brightmore , Inspection Manager at the CQC provided an overview of their findings and highlighted significant improvement and those areas where further improvement is required. We then provided a summary of our reflections and our action plan for the outstanding areas. All stakeholders in the room contributed to the action planning discussion which was focussed on our two main areas where system wide support is required. Feedback from the session was positive and notes of the meeting will be circulated to all attendees.

International Association of Forensic Mental Health Services Annual Conference

Assistant Director of Nursing Julie Warren-Sykes presented a keynote talk on PREVENT duty as a safeguarding issue at the International Association of Forensic Mental Health Services annual conference in Split, Croatia on Thursday 15th June 2017. There were nearly 400 delegates attending from across the world and Julies work and the work of the Trust received a very positive response. Deputy Director Mike Doyle also presented a paper on medium secure units and outcome measures, which prompted much debate and plans have been made for future collaboration with services across the UK.

Quality Headlines

CQC new inspection regime

The CQC , Shaping the future, was published in May 2016, and sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation. This response was published in June.

Changes made from the first phase consultations are:
• Changes to the assessment frameworks for NHS trusts
Assessment frameworks to help complex providers and those with more than one type of service have been simplified.
New content to strengthen specific areas and reflect current practice has been included, and improved wording to simplify the language to aid clarity and understanding has been added. Also the changes to help providers who use the frameworks for their own internal assessment and training purposes have been highlighted.

The CQC will introduce the new assessment framework and approach for NHS trusts from the second half of June 2017.

Second phase consultation
The CQC have now launched the second phase consultation on their proposed changes, which seeks views on specific proposals for how they will:
• improve the structure of registration and clarify our definition of registered providers
• monitor, inspect and rate new models of care and large or complex providers
• use our unique knowledge to encourage improvements in the quality of care in local areas
• regulate primary medical services and adult social care services
• carry out our role in relation to the fit and proper persons requirement.
The CQC state they want to keep the elements that they know people value, and to improve what people tell them they can do better. They will continue to work with people who use services, providers, professionals and our other local and national partners to co-produce what we do.

Infection prevention & control

- In Q1 there has been 1 confirmed case of C difficile for Barnsley BDU (MVH), yet to go to PIR, but it is highly likely this will be classed as unavoidable. Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 6
- Mandatory training targets remain stable constantly above 80% threshold.
- Hand Hygiene-Trust wide Total – 88%
- Infection Prevention and Control- Trust wide Total – 83%
- An experienced IPC specialist nurse has taken a secondment opportunity to support Locala for 22.5hr for 6 months. We are hoping to backfill to the post and hoping to maintain business as usual. This situation will be monitored.

Commissioning for Quality and Innovation (CQUIN)

The Trust submitted its quarter 4 returns at the end of April. Validation by all commissioners has not yet been undertaken due to awaiting some national data and final validation of indicators. It is anticipated that this will be undertaken by the end of May 17.

A shortfall against target of £281k is anticipated for Q4. This is largely in line with forecast.

For 2017/18 the CQUIN schemes will be part of a national two year scheme and will run until 2018/19. The scheme is intended to deliver clinical quality improvements and drive transformational change, supporting the ambitions of the Five Year Forward View and directly linking to the NHS Mandate. A number of the indicators work across partner organisations and collaboration will be required. The national CQUIN indicators on improving the health of our staff, and Physical Health for people with Severe Mental Illness are retained from the 2016/17 scheme and new indicators for the Trust will be:
• Preventing ill health by risky behaviours – alcohol and tobacco
• Child and Young Person MH Transition
• Improving services for people with mental health needs who present to A&E
A Trust lead for each of these indicators has been identified, some preliminary discussions have taken place with commissioners and work continues to review the indicators in conjunction with the commissioner and work streams are being established. Progress on this will be monitored via the Trust CQUINS leads group.

0.5% of CQUIN for 17/18 is dependent upon achievement of 16/17 control total and 17/18 STP performance.
Forensic services will continue with the national forensic scheme, this will include 2 indicators, both of which the indicators are a continuation of the 2016/17 scheme:
• Recovery colleges for medium and low secure patients
• Reducing restrictive practices within adult low and medium secure services.

Quality Headlines

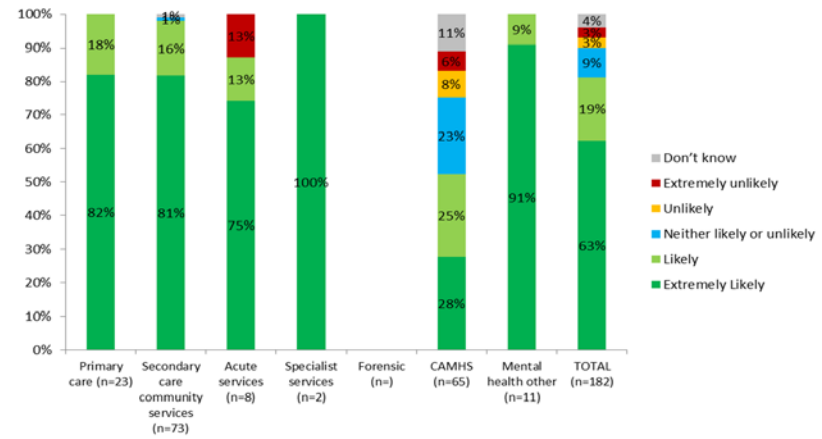
Patient Experience

The customer services annual report is included at agenda item 6.2 of the public session and contains further analysis.

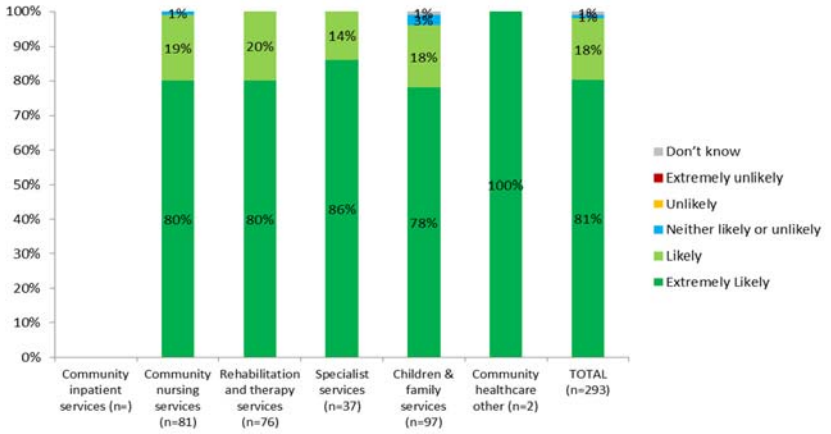
Friends and family test shows

- Community Services – 99% would recommend community services.
- All service lines achieved 78% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
- Mental Health Services – 82% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust– between 28% (CAMH services) and 100% (Specialist services)
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Information Governance

- None of the reported breaches, year to date, have met the criteria for reporting to the ICO.
- Whilst the average number of breaches remains largely the same, the category of breach has shifted from incidents caused by incorrect addresses, this indicates that the extra IG training and communications in addition to the work that has been undertaken to correct mismatched demographics are having some impact.
- There has been a rise in incidents of confidential conversations being overheard and of confidential papers being left in consulting rooms, patients' rooms, etc - each of these are being reviewed as they occur and any themes will be identified to allow for mitigating action to be undertaken.

This section of the report outlines the Trusts performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Single Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. During 16/17, NHS Improvement introduced a new framework for monitoring provider's performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The below table lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the Mental Health Taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Single Oversight Metrics

KPI	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Health & Wellbeing	Responsive	SR	92%	98.2%	97.0%	97.5%	98.7%	98.9%	97.8%	4	
Maximum 6-week wait for diagnostic procedures	Health & Wellbeing	Responsive	SR	99%	99.6%	100%	100%	100%	99%	100%	4	
% Admissions Gatekept by CRS Teams	Health & Wellbeing	Responsive	SR/KT	95%	96.9%	99.3%	99.2%	99.3%	95.6%	98.3%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Health & Wellbeing	Safe	SR/KT	95%	96.7%	97.8%	97.3%	97.5%	98.3%		4	
Data completeness: Identifiers (mental health)	Health & Wellbeing	Responsive	SR/KT/CH	95%	98.1%	99.7%	99.8%	99.7%	Data Not avail [3]	99.7%	4	
Data completeness: Priority Metrics (mental health)	Health & Wellbeing	Responsive	SR/KT/CH	85% *(by end March 17)*	Reporting developed from Oct 16		42.3%	61.1%	Data Not avail [3]	Data avail end June	2 *	
IAPT - proportion of people completing treatment who move to recovery [1]	Health & Wellbeing	Responsive	SR/KT	50%	50.1%	52.5%	48.0%	50.5%	45.6%	49.4%	3	
IAPT - Treatment within 6 Weeks of referral [1]	Health & Wellbeing	Responsive	SR/KT	75%	76.1%	83.6%	88.9%	86.0%	80.3%	84.17%	4	
IAPT - Treatment within 18 weeks of referral [1]	Health & Wellbeing	Responsive	SR/KT	95%	98.9%	99.3%	97.9%	99.9%	99.6%	99.44%	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Health & Wellbeing	Responsive	SR/KT	50%	77.5%	82.0%	82.2%	73.6%	86.1%	88.9%	4	
% clients in settled accommodation	Health & Wellbeing	Responsive	DS	*60%*	Reporting developed from Sept 16		82.7%	82.9%	Data Not avail [3]	Data avail end June	4	
% clients in employment	Health & Wellbeing	Responsive	DS	*10%*	Reporting developed from Sept 16		8.3%	8.8%	Data Not avail [3]	Data avail end June	1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Health & Wellbeing	Responsive	SR/KT		Performance due to be published end May 17				Due Q4		2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Year End Forecast Position *	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Health & Wellbeing	Safe	KT/SR/CH	*TBC*	14	2	60	86	0	1	N/A	
Total number of Children and Younger People under 18 in adult inpatient wards	Health & Wellbeing	Safe	KT/SR/CH	*TBC*	4	1	4	3	0	1	N/A	
Number of detentions under the Mental Health Act	Health & Wellbeing	Safe	KT/SR/CH	*TBC*	167	174	156	168	Data avail at Qtr end		N/A	
Proportion of people detained under the MHA who are BME [2]	Health & Wellbeing	Safe	KT/SR/CH	*TBC*	15.0%	10.3%	10.9%	19.6%			N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Year End Forecast Position *	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1]	Health & Wellbeing	Responsive	KT/SR/CH	90%	97.8%	97.9%	97.8%	98.0%	Data Not avail [3]	95.9%	4	
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Health & Wellbeing	Responsive	KT/SR/CH	99%	99.5%	99.6%	99.7%	99.7%	Data Not avail [3]	Data avail end June	4	
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Health & Wellbeing	Responsive	KT/SR/CH	90%	89.6%	91.1%	94.0%	90.2%	Data Not avail [3]	Data avail end June	4	

** See key included in glossary.*

[1] - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.

[2] - BME includes mixed, Asian/Asian British, black, black British, other

[3] - There was no April Primary submission this month due to the transition to MHSDS v2. Data to flow monthly from May 17 onwards.

Areas of concern/to note:

IAPT - proportion of people completing treatment who move to recovery – In April and May the Trust has not achieved the 50% threshold this month (49.4%). Underperformance is attributed to Kirklees (43.6%) and Barnsley (42.1%). Work continues to taking place within both services to review the data – Kirklees are focusing on data quality and Barnsley are undertaking a review of the referrals to identify whether there are issue with referral appropriateness.

Max time of 18 weeks from point of referral to treatment - incomplete pathway - no performance issues to flag for May 17 however, from 1st June the implementation of the Diabetes SPA in Barnsley, which is hosted by SWYPFT, will mean that additional data will flow into this line from next month as the service aligns to the RTT reporting definition. Some risk in achievement has been identified, however this is based on the SWYPFT only element of data and it has been acknowledged there are a number of data quality issues impacting. A number of mitigating actions have been put in place as part of the SPA implementation which will assist with the position going forward. Data is being monitored on a weekly basis, however it is unlikely we will see the impact of this until late September/early October.

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

Barnsley BDU:

• In response to apparent underperformance against activity targets for IHBTT, managers and P&I have undertaken diagnostic work and remedial action around how contacts are recorded and counted. This has resulted in a more accurate picture of activity in the team, moving from significant underperformance to an over performance of 34% in this month's report
• Work is ongoing around the development of the core service as part of the new model following Transformation. Trios are in discussion with the Core teams and the Transformation team to develop supportive plans to embed the new ways of working in the BDU.
• Sickness we are refreshing training to all levels of staff in order to strengthen our focus.
• New respiratory model – activity will be changing and under the Alliance contract BHNFT will be the lead, so we need to note the effect this will have in Q2.

Calderdale & Kirklees BDU:

• Discussions have taken place with NHS North Kirklees and Greater Huddersfield CCGs to discuss the model for in-patient and community Rehabilitation services. Similar discussions have also taken place with Calderdale CCG.
• Early Intervention Psychosis 14 day is at 68% and well above target.
• Delayed transfers of care remain improved but under constant scrutiny.
• Meeting with Calderdale CCG on Psychology waiting has been helpful and further actions have been agreed to review its access protocols to IAPT for longer term support and to discuss with Primary Care controls over referrals to the service.

Forensics BDU:

• Recruitment of Registered Nurses continues to be a challenge with 23 Band 5 vacancies across the BDU. These vacancies have been appointed to, but staff are not due to commence work with the Trust until September meaning the service will have significant gaps throughout the summer period. There are a further 10 vacancies comprising of more senior posts, AHP roles and unregistered staff vacancies. The service have a fortnightly Workforce Review meeting which focuses on ensuring that activity is focused on ensuring there are adequate numbers of staff to deliver a safe service. Over recruitment of unregistered staff is on track and we envisage this will help to reduce the cost of agency which has been significant in recent times.
• 25 Hours activity. The Medium and Low secure services have intermittently struggled to meet this target. Earlier attempts to remedy this were not consistently successful. The service has undertaken a larger piece of work involving frontline staff to determine the barriers to achievement of this target. Several reasons were identified. As a result staff have been involved in redefining categories with some solutions found to recording being made as easy as possible. We have re-launched the revised criteria and ward managers will work with staff to this is embedded in practice. More timely reporting from P&I should enable remedial action to be taken as soon as possible.
• Occupancy is currently:
YTD cumulative position is:

	Apr	May
Med Secure (exclude Gaskell)	87%	86.5%
Low Secure (include Newhaven)	86.5%	84.7%
TOTAL	**86.8%**	**85.8%**

Although commissioners have indicated that a financial penalty will not be incurred the service will remain focused on this issue and work with NHSE to ensure optimum and appropriate use of beds. A number (but not all vacant beds) are in our LD services which is a likely result of the Transforming care agenda. The service is due to meet with NHSE in the near future to explore potential solutions.

Specialist BDU:

CAMHS
• A New Model of Care bid submitted as part of the West Yorkshire and Harrogate STP and West Yorkshire Mental HealthTrust Collaborative has been approved by NHSE. This will provide for project management support in developing more robust and consistent approaches to reducing the need for inpatient stays - for example through creating safe space alternatives.
• From 5 June 2017 a strengthened on call system has been introduced – incorporating a management on-call function.
• CAMHS was the focus of a Barnsley Council Overview and Scrutiny Committee on 21 June 2017. The significant progress in reducing waits for initial assessment and plans regarding creation of a new SPA function were noted. However, waiting times for treatment remained unsatisfactory and it was recognised that improvement work in this regard must be prioritised.
• Whilst the 18 week waiting time for treatment benchmark has been achieved in Calderdale/Kirklees Barnsley and Wakefield remain significantly outside this standard. The waiting list initiatives have provided impetus for a notable reduction in the number waiting for treatment in Barnsley - with the reduction most evident in the number of children/young people waiting the longest (i.e. over 6 months). In recognition Barnsley commissioners agreed to extend funding until June 2017. The increase in numbers waiting in Wakefield is due to the greater volume of primary care practitioner activity (where children/young people are identified to be 'waiting' but are seen very quickly).

Learning Disability
• Robust reporting and charging arrangements are now in place with regard to the 2 spot purchase in-patient beds. A marketing plan is being developed to ensure high occupancy levels are maintained.

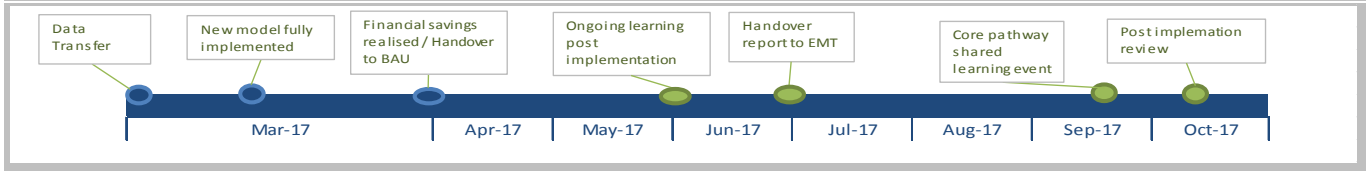
Wakefield BDU:

• The management team have noted a downward trend in % of responses within 4 hours over recent months. Work is ongoing to understand this and to take positive action to improve this going forward.
• Wakefield Community services achieved the highest response rate in the Trust to the recent Wellbeing survey at 85.35% There was a significant improvement from last year's survey as a result of a detailed action plan and real engagement with staff to address issues raised. The high response rate against a backdrop of Transformation, moving into the Hubs and introduction of Agile working endorses the hard work of the team to support the wellbeing of staff
• Work is ongoing around the development of the Core service as part of the new model following Transformation. Trios are in discussion with the Core teams and the Transformation team to develop supportive plans to embed the new ways of working in the BDU

This section of the report reports the Trust's progress against the identified transformation projects.

Acute & Community Mental Health Transformation Project

The Trust has implemented the 'core and enhanced' community pathways which have been designed through this project. These services went live on 3rd April 2017, and there is continuing work planned throughout the year to embed the new ways of working and ensure consistency of service development is maintained. Each BDU currently has working groups in place to support the implementation and learning is being shared across the organisation. The implementation of the enhanced pathway has been going well across the trust. There have been some issues in the core pathway because of the amount of change required - these are being positively addressed in each BDU and an event to focus on core pathway implementation is being scheduled for September 2017 when services are more embedded. A project closure report has been completed and shared with the mental health transformation work stream board in May. Additional finance information is being added to the report, which will then go to EMT in late June or July for agreement to handover to business as usual.	Delivery against plan	
Feedback from BDUs suggests that whilst the enhanced part of the new pathway is working well, that there have been initial issues in the core pathway. A meeting is being organised to consider the issues and further activity will be planned as / if necessary.	Management of risk	
Benefits arising from this project will be: more flexible and responsive deployment of resources; simpler and faster core pathway, supporting sustainable recovery. Savings from the transformation are currently being established and will form part of the project closure report. The Business Delivery Units are now embedding the new system structures and achievement of benefits will be measured at the 6 and 12 months post implementation reviews (October 2017 and April 2018).	Benefits Realisation	
QIAs for each BDU were signed off by the Quality Team in January 2017. A benefits framework has been established to track the delivery of the quality improvements and these will be tracked in the year post implementation.	Quality impact	



Older Peoples Mental Health Transformation Project

Work is progressing well toward the business case although there has been some slippage due to changes in the project team and challenges of agreeing new workforce models. A revised plan is in draft that rebases the project. Commissioner engagement has happened with all commissioners and there has been positive feedback overall to the principles of the new model, in particular pleased that the model supports integration across all our older people's services whilst protecting the specialisms and specialities of our staff. Working groups have been held to map future pathways in detail to inform workforce modelling. A task and finish group is making good progress toward agreeing preferred options and are currently considering the clinical quality of the future environment, access and travel, and financial sustainability	Delivery against plan	
There remains a risk that some financial benefits identified can't be fully realised if parts of the community workforce require enhancing. The project team has now met all commissioners following a positive meeting with Barnsley in May and the project team and the BDU are meeting to draft a response to some follow on queries.	Management of risk	
Benefits are targeted in 2018/2019 options will be modelled up and considered in the business case, due to be completed by end July/early August.	Benefits Realisation	
Extensive engagement around clinical model provides assurance of positive quality impact. A Quality Impact Assessment will be produced with the business case.	Quality impact	

Rehab and Recovery Transformation Project

A community service model is agreed in principle with local CCGs and has been implemented in Wakefield. Implementation in Calderdale is expected in 2017/2018. In Kirklees, a plan is now in place to reduce patient numbers in Enfield Down and establish resource that could support a community service model – this work had been delayed whilst awaiting agreement on the future model and it is now hoped that this can progress more quickly. The project scope in Kirklees for the full system model is still to be agreed - however strategic discussions between the BDU and Kirklees commissioners have been positive and it is hoped quick progress will be found on a way forward.	Delivery against plan	
Risk that there is not a consistent approach o service provision across West Yorkshire	Management of risk	
Financial benefits have already been realised in Wakefield and further financial savings are anticipated in Calderdale during 2017/18. All parties are keen to reinvest savings in mental health where possible.	Benefits Realisation	
The project undertook a Quality Impact Assessment in design phase, and a new QIA plus further engagement is likely to be required following decisions on how to progress activity in Kirklees.	Quality impact	

Barnsley Therapy Services Review

A revised project closure report is due for submission to Barnsley BDU Management Team by end of June 2017. The move to 'business as usual' for the Therapy Services has taken place and the roll out of SystmOne across all therapy services continues. This project has now been formally closed.	Delivery against plan	
	Management of risk	
The purpose of phase one of this project was to bring together therapy administration to create a therapy single point of access and bring together appropriate clinical therapies to efficiently utilise skills and knowledge across services and provide most effective quality care to patients. Phase one was completed successfully. Any savings made through Therapy administrative services reconfiguration have been counted as part of the Barnsley Administrative Services Review. Any other benefits will be summarised in the project closure report. PMO will support Barnsley services to perform a benefits realisation review in December 2017.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated a positive impact on quality through co-location and creation of centres of excellence, but also noted that consolidation of services moves some provision further from communities. The QIA will be revisited and updated to reflect the changes undertaken in service.	Quality impact	

Barnsley Community Nursing Transformation

Service mobilisation is complete. Whilst supportive training and development, including systems leader sessions, and agile working rollout continue, the service has moved into business as usual. Work has commenced, in conjunction with CCG, to plan a celebrating success event scheduled for the summer. A revised project closure report is due for submission to Barnsley BDU Management Team by end of June 2017.	Delivery against plan	
	Management of risk	
The purpose of this project is to: ensure the right person, right contact, and right time; and to equip more patients to self-care; better integrate community nursing, care navigation teams, and establish integrated teams in localities which align with primary and social care. In 2016, the delivery direction of the project changed to reflect local commissioner intentions and the issue of a new service specification. Outcome measures have been agreed with BCCG and monthly reports on attainment are provided to BCCG. Benefits realised will be included in the project closure report. PMO will support Barnsley services to perform a benefits realisation review in December 2017.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated positive impact on quality. This is being repeated and updated to reflect the changes in services. Patient and carer surveys have been undertaken and submitted to BCCG. An updated QIA is scheduled for completion by end of June 2017.	Quality impact	

Key for Transformation:			
Implementation deliverables		**RAG Ratings**	
	On Target to deliver within agreed timescales		On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver within agreed timescales		On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales		Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	Action will not be delivered within agreed timescales		Actions will not be delivered within agreed timescales/project tolerances
	Action Complete		Action Complete

This section of the report reports the Trust's progress against the identified Trust priorities for 2017/2018.
The framework below is a proposal for how we will report on progress with Trust priorities. Initially this will show the necessary components each programme needs to have in place to get started (SRO, scope, operational lead, clinical lead and programme and change manager, etc) and then report on progress against plan, risk and benefits in subsequent updates.
In respect of the priority programmes so far we can report that:

- Director SROs for each priority programme are confirmed
- SROs and Integrated Change Team are meeting to agree support requirements by end June
- Governance arrangements for each priority programme confirmed and established in July
- Milestones for each priority programme to be confirmed in July
- Regular reporting on milestones and KPIs via IPR from July onwards
- Trust Board is already sighted on progress being made in Barnsley and Wakefield in respect of ACO development
- Procurement process for clinical record system is approaching completion

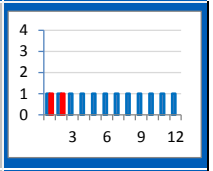
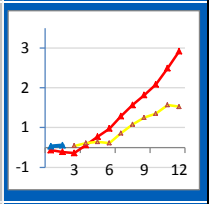
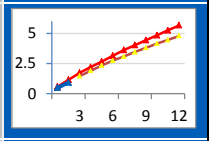
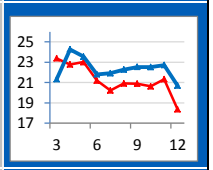
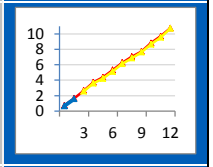
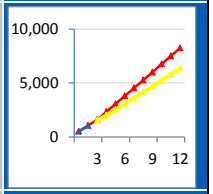
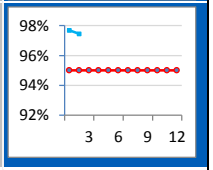
	Governance													Scoping Phase								
	SRO Identified		Scope Agreed		Governance Route Agreed		Clinical lead Identified		Operational lead Identified		Change Manager Identified		RAG	1st Draft PID		Clinical Lead input		SRO Sign Off		Governance Board Approval		RAG
IMPROVING HEALTH																						
Strategic Priority One: People First																						
1.1 Enhancing Liaison Services	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
1.2 Improving people's experience	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
1.3 Recovery based approaches	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
1.4 Physical /Mental health	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
Strategic Priority Two: Joining up Care																						
2.1 Supporting place-based plans	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
2.2 Accountable Care in Barnsley and Wakefield	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
2.3 New models of care and vanguards	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	

IMPROVING CARE																					
Strategic Priority Three: Quality Counts, Safety First																					
3.1 Patient Safety	Please see the Quality section of the report.																				
3.2 Older People's MH transformation	Please see the transformation section of the report.																				
3.3 Improving autism and ADHD	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
3.4 Perinatal mental health	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
3.5 West Yorkshire work – CAMHS, forensics, suicide prevention	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
3.6 Quality priorities	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
Strategic Priority Four: Compassionate Leadership																					
4.1 Leadership development	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
4.2 Change and quality improvement	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
4.3 Membership	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	

IMPROVING USE OF RESOURCES																					
Strategic Priority Five: Operational Excellence																					
5.1 Flow and out of area beds	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
5.2 Workforce – sickness, rostering, skill mix and agency	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
5.3 Effective use of supplies and resources	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
5.4 CQUIN	Please see the Quality section of the report.																				
5.5 Financial sustainability and CIP	Please see the finance section of the report and supporting appendix.																				
Strategic Priority Six: Digital by Default																					
6.1 Clinical record system	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
6.2 Digital health	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	
6.3 Data driven improvements and innovation	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date	✓	Date		✓	Date	✓	Date	✓	Date	✓	Date	

RAG Ratings	
	On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	Actions will not be delivered within agreed timescales/project tolerances
	Action Complete

1.0 Finance Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative	Trend
1	NHS Improvement Risk Rating	1	1	The NHS Improvement financial risk rating is 1 for the year to May 2017. All metrics, with the exception of the I & E margin, are 1. I & E margin needs to be increase to greater than 1% to score 1. (approximately a £100k increase in surplus to date).	
2	Normalised Surplus	£0.2m	£2.4m	May 2017 finance performance excluding STF is a small surplus of £27k. Including STF this is a surplus of £97k. The forecast is currently in line with plan. Out of Area beds (in month £164k overspend) and Agency staff (as below) continue to be a pressure in 2017/18 and subject to focused attention.	
3	Agency Cap	£1.2m	£7.0m	Agency expenditure in May 2017 is £0.4m. The agency cap for 2017 / 2018 is £5.7m. Review, validation and actions at an individual post level continue.	
4	Cash	£21.5m	£20.7m	The month 2 cash position is lower than planned primarily due to 2016 / 2017 STF receipts and other timing issues.	
5	Capital	£1.6m	£10.7m	Capital expenditure is marginally behind plan in month 2 due to delays in minor capital schemes and IM & T projects.	
6	Delivery of CIP	£1m	£6.4m	Year to date CIP delivery is £50k behind plan. Overall the forecast position is £1.9m below plan. Themes are being developed to close this gap with specific schemes in progress with executive director leads. e.g. effective rostering, temporary staffing review.	
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.	

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

Plan
Actual
Forecast

Contracting

Contracting Issues - General

Following the production of the Joint assurance letters with CCGs providing preliminary assurances in relation to growth in Mental Health investment in line with the Five Year Forward View, meetings are being arranged with individual CCGs. Investment in Five Year Forward View (FYFV) will be monitored with the Wakefield, Calderdale and Kirklees CCGs through the Partnership Board and in Barnsley through the Contract Management Executive Board. At a strategic level preparation for the development of New Models of Care are key priority areas. Contracting workstreams have now been established to underpin the contractual formats for the development of an Accountable Care Organisation in Barnsley and the development of a Multispecialty Community Provider in Wakefield.

CQUIN

Work continues internally and with commissioners to ensure clarity on definitions and required data sets in relation to 17/18 CQUINs. Work continues on implementation of systems and processes for 17/18 CQUINs.

QIPP

There are no specific Cash releasing QIPP targets for 17/18.

Contracting Issues – Barnsley

Implementation of the new models of care for the Neighbourhood Nursing Service continues as part of the Alliance Contract. A commercial workstream has now been established as part of the governance arrangements for the creation of Accountable Care Organisation in Barnsley. Following the joint assurance on Five Year Forward View Investment submitted to NHS E progress and updates will be monitored through the Contract Management Executive Board. Key strategic work areas as part of the contract service development plan relate to Intermediate Care Services, Respiratory, Diabetes and MSK Services.

Contracting Issues – Calderdale

Following the joint assurance on Five Year Forward View Investment submitted to NHS E, progress and updates will be monitored through the quarterly Partnership Board. Discussions continue regarding a sustainable specialist ASD Services for Adults, a sustainable 24/7 crisis resolution service and pressures within Psychology service. Key ongoing workstreams include the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Confirmation has been received from NHS E of successful application for funding in 2018/19 related to full implementation of services to meet core 24/7 Mental Health Liaison requirements jointly with Greater Huddersfield.

Contracting Issues – Kirklees

Following the joint assurance on Five Year Forward View Investment submitted to NHS E, progress and updates will be monitored through the quarterly Partnership Board. The current priority areas of work related to Kirklees CCG's contracts include IAPT services and expansion to Long Term Conditions and the reconfiguration of adult mental health rehabilitation services. Discussions continue regarding a sustainable specialist ASD Services for Adults. Key ongoing workstreams include the mobilisation and implementation of the expansion of IAPT services to Long Term Conditions and full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. For Greater Huddersfield confirmation has been received from NHS E of successful application for funding in 2018/19 related to full implementation of services to meet core 24/7 Mental Health Liaison requirements jointly with Calderdale. For North Kirklees, confirmation has been received from NHS E of successful application for funding in 17/18 related to full implementation of core 24/7 Mental Health Liaison requirements jointly with Wakefield.

Contracting

Contracting Issues- Wakefield

Following the joint assurance on Five Year Forward View Investment submitted to NHS E, progress and updates will be monitored through the quarterly Partnership Board. The commissioning of an Adult ASD assessment, diagnostics and treatment service commenced from 1 April 2017. A virtual MCP model will be mobilised in April 2017, and an alliance contract arrangement with other system partners will be entered into. The new contract for the provision of the Social Wellbeing Service jointly between SWYPFT and Nova commenced from 1 April 2017. A key ongoing workstream includes the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Confirmation has been received from NHS E of successful application for funding in 17/18 related to full implementation of core 24/7 Mental Health Liaison requirements jointly with North Kirklees.

Contracting Issues - Forensics

The key area of monitoring continues to relate to the occupancy target. The sub contract for advocacy services is currently being procured.

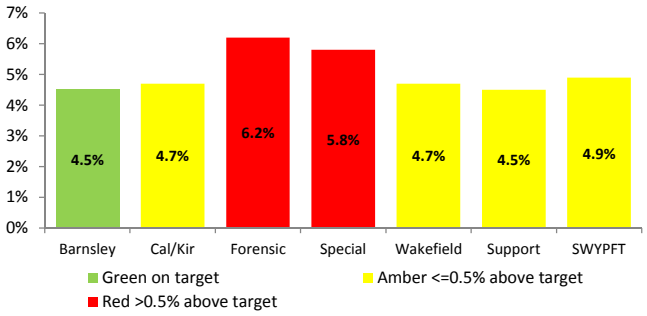
Contracting Issues – Other

The re-procurement of smoke free services for Sheffield formally commenced on 28th April 2017. SWYPFT holds the contract until 30th September. Doncaster smoke free services are due for re-procurement in June. SWYPFT holds the contract until 31st March 2018.

Workforce

Human Resources Performance Dashboard - May 2017

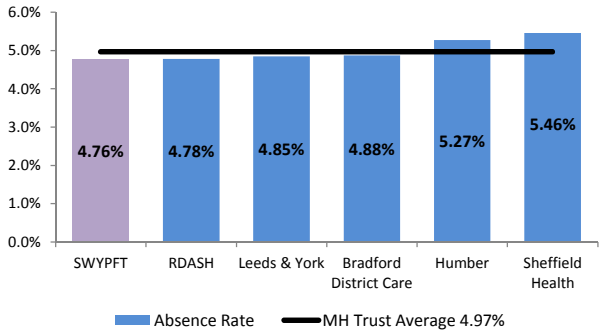
Sickness Absence



Current Absence Position - May 2017

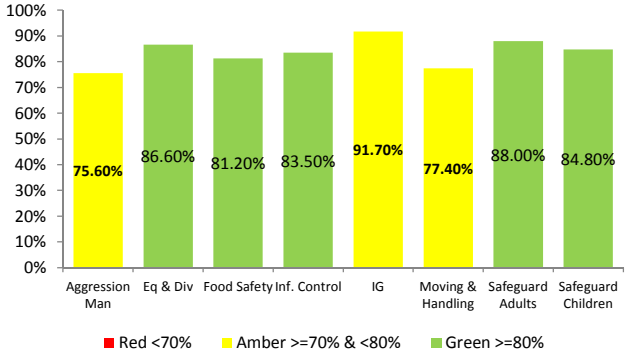
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.5%	4.8%	5.3%	5.7%	4.4%	4.7%	4.8%
Trend	↓	↔	↓	↑	↓	↑	↓

The Trust YTD absence levels in May 2017 (chart above) were above the overall 4.5% target at 4.9%.



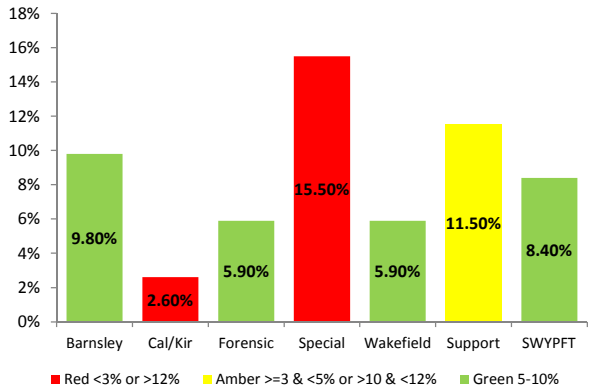
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 6 months from April to September 2016.
During this time the Trust's absence rate was 4.76% which is below the regional average of 4.97%.

Mandatory Training

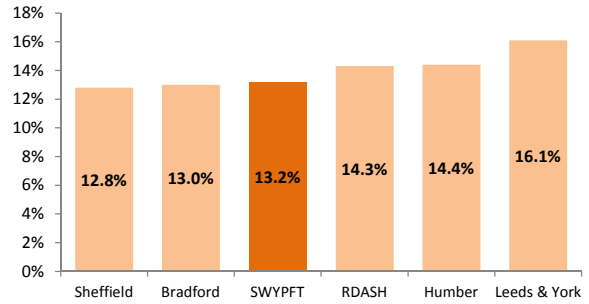


The above chart shows the mandatory training rates for the Trust to the end of May 2017.
Apart from Information Governance (IG), all mandatory training has a target of above 80%; IG has a target of above 95%; all are based on a rolling year.

Turnover and Stability Rate Benchmark

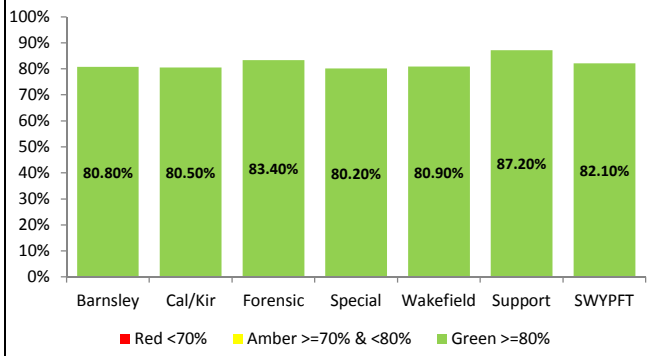


This chart shows the YTD turnover levels up to the end of May 2017.
Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.



The above chart shows turnover for registered nurses during 2016/17.
The Trust's figures have been adjusted to exclude leavers as part of the 0 - 19 transfer.

Fire Training Attendance



The chart shows the YTD fire lecture figures to the end of May 2017.
The Trust continues to achieve its 80% target for fire lecture training and all areas are now above the target.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.6%	4.7%	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%	5.1%	4.9%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.8%	5.0%	4.7%	4.6%	5.2%	5.8%	6.1%	5.8%	5.3%	4.9%	4.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	56.7%	71.0%	81.4%	84.8%	89.8%	93.2%	93.7%	94.4%	94.9%	5.2%	17.6%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	26.8%	44.3%	68.5%	76.8%	84.9%	89.0%	91.4%	92.8%	93.6%	1.9%	5.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.8%	81.0%	82.4%	80.0%	78.8%	78.4%	77.6%	77.2%	76.6%	76.4%	75.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80% by 31/3/17	62.0%	60.6%	63.2%	65.0%	66.9%	69.7%	72.8%	73.8%	73.9%	75.2%	75.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80% by 31/3/17	28.2%	39.0%	41.0%	39.9%	45.1%	53.5%	55.3%	60.4%	62.2%	64.8%	65.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.9%	91.7%	90.9%	90.3%	89.4%	90.1%	89.0%	89.4%	88.2%	87.3%	86.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.5%	85.1%	84.6%	83.7%	82.9%	85.5%	84.0%	82.9%	82.7%	81.5%	82.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.8%	82.2%	81.8%	82.6%	82.9%	83.9%	82.9%	82.6%	82.1%	82.6%	81.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.8%	83.4%	82.5%	81.3%	81.9%	83.8%	83.6%	83.6%	83.4%	83.0%	83.5%
Information Governance	Resources	Well Led	AD	>=95%	90.2%	89.2%	88.2%	86.5%	85.9%	86.5%	91.9%	95.2%	96.1%	92.0%	91.7%
Moving and Handling	Resources	Well Led	AD	>=80%	82.2%	79.4%	78.2%	77.0%	78.1%	78.8%	80.5%	81.9%	81.7%	81.1%	77.3%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80% by 31/3/17					12.9%	46.0%	48.2%	53.1%	64.1%	64.9%	69.6%
Mental Health Act	Quality & Experience	Well Led	AD	>=80% by 31/3/17					11.0%	20.9%	23.2%	30.5%	47.9%	51.2%	56.9%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.1%	89.7%	89.2%	89.0%	88.6%	89.5%	89.7%	89.4%	89.1%	88.5%	88.0%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.3%	88.2%	88.0%	86.7%	87.0%	87.8%	87.6%	87.0%	85.6%	85.5%	84.8%
Sainsbury's clinical risk assessment tool	Health & Wellbeing	Well Led	AD	>=80%	97.1%	96.9%	96.6%	93.2%	93.8%	94.8%	95.1%	94.7%	93.7%	93.3%	91.2%
Bank Cost	Resources	Well Led	AD	-	£434k	£512k	£605k	£486k	£458k	£477k	£505k	£493k	£722k	£398k	£457k
Agency Cost	Resources	Effective	AD	-	£791k	£989k	£833k	£833k	£753k	£885k	£662k	£729k	£833k	£501k	£426k
Overtime Costs	Resources	Effective	AD	-	£23k	£17k	£9k	£16k	£14k	£26k	£19k	£15k	£12k	£16k	£13k
Additional Hours Costs	Resources	Effective	AD	-	£78k	£52k	£48k	£40k	£41k	£47k	£41k	£48k	£53k	£56k	£36k
Sickness Cost (Monthly)	Resources	Effective	AD	-	£481k	£504k	£501k	£447k	£511k	£565k	£592k	£527k	£561k	£479k	£503k
Business Miles	Resources	Effective	AD	-	286k	300k	273k	328k	330k	316k	284k	287k	273k	289k	245k

Workforce - Performance Wall cont…

Notes:

Mandatory Training

The Trust is achieving above the compliance target for all areas with the exception of:

• Information Governance – 91.7% which is a 0.3% decline from last month. The majority of services are between 90% and 100%. We are awaiting the updated training programme from NHS Digital.

• Aggression Management – 75.6%, which is 1.2% lower compliance rate from last month. All Clinical Mental Health In-patient Services are achieving their compliance target. The MAV team have put on a number of extra training sessions to the ones already scheduled to improve compliance further

• Cardio Pulmonary Resuscitation - 75.3%, this continues on an upward trajectory

• Clinical Risk – 65.3%, this continues on an upward trajectory. Staff are already trained in clinical risk. This training is part of our safety improvement plan. Therefore priority has been given to the MHA/MCA until end of Q1.

• Moving and Handling – 77.3%, which is a 3.8% decline on last month

• Mental Capacity Act/DOLS – 69.6% (last month 64.9%). This continues on an upward trajectory each month. Service areas with low compliance are being offered specific training for their service to support and improve compliance

• Mental Health Act – 56.9% (last month 51.2%) of mental health staff have achieved this. The biggest uptake is from In-patient Registered Clinical Staff which is 69.9% and increasing each month. Service areas with low compliance are being offered specific training for their service to support and improve compliance

Some services are experiencing difficulties in releasing staff to attend MCA and MHA training due to clinical priorities. Therefore, bespoke training continues to be offered and delivered to services,. The Trust has a training schedule throughout 2017/18 to increase the compliance percentage.

Sickness

• The Trusts YTD position remains at 4.9%, which continues to be above the Trusts threshold. The Trusts monthly sickness level has seen a slight reduction compared to April 17.

• Forensic (6.2%) and Specialist Services (5.8%) BDUs continue to report the highest sickness levels although there has been a significant drop in reported levels during May 17 in the Forensic BDU which reduces the ytd position to 6.2% from 7.2%.

• BDUs continue to focus on long term sickness and the recent staffing summit identified some further potential areas which are being explored that may assist with reducing sickness absence.

Publication Summary

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

Seasonal flu vaccine uptake in healthcare workers in England: winter season 2016 to 2017

Referral to treatment waiting times statistics for consultant-led elective care: March 2017

Monthly hospital activity data: March 2017

Early intervention in psychosis access and waiting time experimental statistics: March 2017

Diagnostics waiting times and activity: March 2017

Delayed transfers of care: March 2017

Children and young people with an eating disorder access and waiting times, experimental statistics: Q4 2016/17

NHS Improvement provider bulletin: 10 May 2017

Children and young people's health service statistics, England: January 2017, experimental statistics

Mental health community teams activity data: Q4 2016/17

Combined performance summary, March 2017

Provisional monthly hospital episode statistics for admitted patient care, outpatients and A&E data: April 2016 to March 2017

NHS Improvement provider bulletin: 17 May 2017

Direct access audiology, March 2017

NHS workforce statistics, February 2017, provisional statistics

NHS sickness absence rates, January 2017

Mental health services monthly statistics: final February, provisional March 2017

Improving access to psychological therapies report: February 2017 final, March 2017 primary and most recent quarterly data (Q3 2016/17)

Bed availability and occupancy: Q4 2016-17

Hospital activity statistics: Q4 2016-17

NHS Improvement provider bulletin, 26 May 2017

Learning disability services monthly statistics, England – commissioner census (Assuring Transformation): April 2017, provisional statistics

Out of area placements in mental health services - April 2017

NHS Improvement update: May/June 2017

NHS Improvement provider bulletin: 7 June 2017

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 2 (2017/2018)

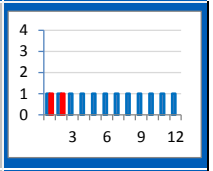
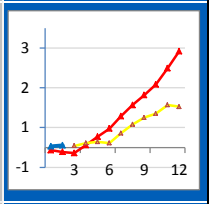
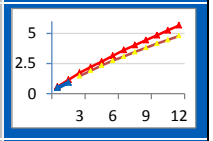
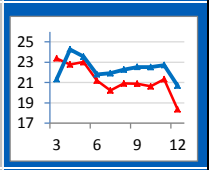
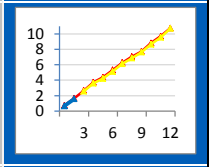
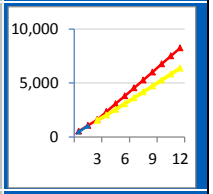
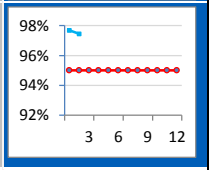
Appendix 1

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative	Trend
1	NHS Improvement Risk Rating	1	1	The NHS Improvement financial risk rating is 1 for the year to May 2017. All metrics, with the exception of the I & E margin, are 1. I & E margin needs to be increase to greater than 1% to score 1. (approximately a £100k increase in surplus to date).	
2	Normalised Surplus	£0.2m	£2.4m	May 2017 finance performance excluding STF is a small surplus of £27k. Including STF this is a surplus of £97k. The forecast is currently in line with plan. Out of Area beds (in month £164k overspend) and Agency staff (as below) continue to be a pressure in 2017/18 and subject to focused attention.	
3	Agency Cap	£1.2m	£7.0m	Agency expenditure in May 2017 is £0.4m. The agency cap for 2017 / 2018 is £5.7m. Review, validation and actions at an individual post level continue.	
4	Cash	£21.5m	£20.7m	The month 2 cash position is lower than planned primarily due to 2016 / 2017 STF receipts and other timing issues.	
5	Capital	£1.6m	£10.7m	Capital expenditure is marginally behind plan in month 2 due to delays in minor capital schemes and IM & T projects.	
6	Delivery of CIP	£1m	£6.4m	Year to date CIP delivery is £50k behind plan. Overall the forecast position is £1.9m below plan. Themes are being developed to close this gap with specific schemes in progress with executive director leads. e.g. effective rostering, temporary staffing review.	
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.	

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

Plan
Actual
Forecast

1.1 NHS Improvement Risk Rating - Use of Resources

The Trust is regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources calculation as outlined below. The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

			Actual Performance		Plan - Month 2	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.2	1	2.6	1
	20%	Liquidity (Days)	18.4	1	14.4	1
Financial Efficiency	20%	I & E Margin	0.5%	2	-0.3%	3
Financial Controls	20%	Distance from Financial Plan	0.8%	1	0.0%	1
	20%	Agency Spend	-20.1%	1	-20.7%	1
Weighted Average - Financial Sustainability Risk Rating				1		1

Impact

The risk rating in month 2 is rated as 1 which is the highest possible score. All metrics are currently at 1 with the exception of I & E margin. This needs to be greater than 1% to achieve a rating of 1.

Definitions

Capital Servicing Capacity - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

Liquidity - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

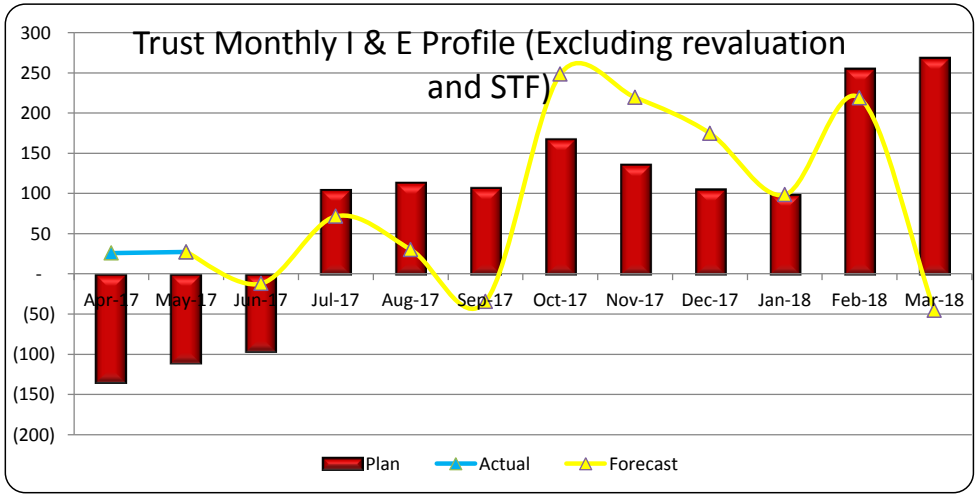
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

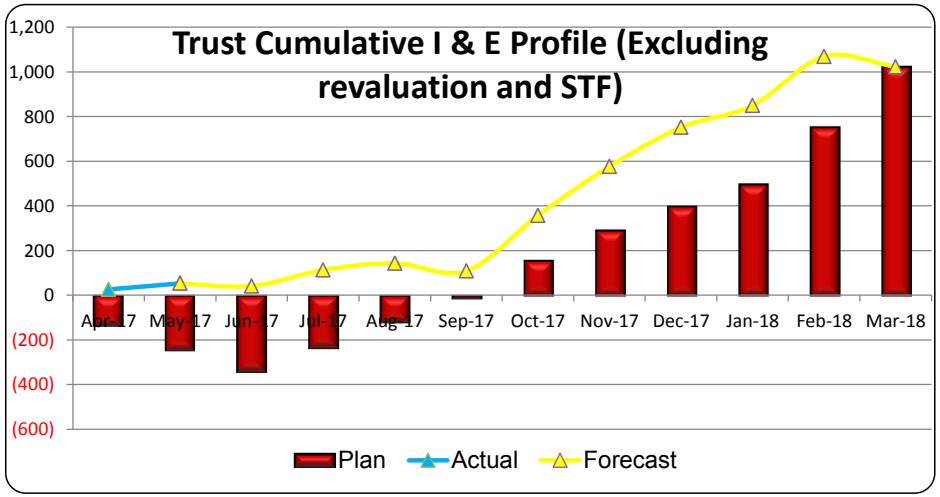
Distance from plan - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

Agency Cap - A cap of £5.6m has been set for the Trust in 2017 / 2018. This metric compares performance against this cap.

2.0 Income & Expenditure Position 2017 / 2018

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				17,260	17,247	(13)	Clinical Revenue	34,483	34,380	(104)	206,645	205,685	(959)
				17,260	**17,247**	**(13)**	**Total Clinical Revenue**	**34,483**	**34,380**	**(104)**	**206,645**	**205,685**	**(959)**
				1,128	1,142	15	Other Operating Revenue	2,213	2,231	18	13,112	13,314	202
				18,388	**18,390**	**2**	**Total Revenue**	**36,696**	**36,611**	**(85)**	**219,757**	**218,999**	**(757)**
4,266	4,141	(124)	2.9%	(14,276)	(13,992)	285	Pay Costs	(28,434)	(27,744)	690	(169,905)	(168,946)	959
				(3,416)	(3,568)	(152)	Non Pay Costs	(6,839)	(6,849)	(10)	(40,663)	(40,881)	(218)
				(19)	7	26	Provisions	(94)	(377)	(283)	881	972	91
4,266	**4,141**	**(124)**	**2.9%**	**(17,711)**	**(17,553)**	**159**	**Total Operating Expenses**	**(35,367)**	**(34,970)**	**397**	**(209,688)**	**(208,856)**	**832**
4,266	**4,141**	**(124)**	**2.9%**	**677**	**837**	**160**	**EBITDA**	**1,329**	**1,640**	**311**	**10,069**	**10,144**	**75**
				(507)	(529)	(22)	Depreciation	(1,014)	(1,027)	(13)	(5,694)	(5,754)	(61)
				(283)	(283)	0	PDC Paid	(566)	(566)	0	(3,397)	(3,397)	(0)
				4	3	(1)	Interest Received	8	6	(1)	45	31	(14)
4,266	**4,141**	**(124)**	**2.9%**	**(110)**	**27**	**137**	**Normalised Surplus / (Deficit) Excl.STF**	**(244)**	**53**	**297**	**1,023**	**1,023**	**0**
				70	70	0	STF	140	140	0	1,394	1,394	0
4,266	**4,141**	**(124)**	**2.9%**	**(40)**	**97**	**137**	**Normalised Surplus / (Deficit) Incl SFT**	**(104)**	**193**	**297**	**2,417**	**2,417**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,266	**4,141**	**(124)**	**2.9%**	**(40)**	**97**	**137**	**Surplus / (Deficit)**	**(104)**	**193**	**297**	**2,417**	**2,417**	**0**





Income & Expenditure Position 2017 / 2018

Trust Normalised Surplus Position (Pre and Post Sustainability and Transformation Funding)

The Trust year to date and forecast finance positions including and excluding STF funding are highlighted below. This excludes exceptional items such as the revaluation of Trust Estate. The total Sustainability and Transformation Funding available in 2017/18 is £1.394m. Payment for Quarter 1 will be based on the trusts' delivery of financial control total year-to-date trajectories. At Month 2 the STF is forecast to achieve.

	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
Surplus (Excluding STF)	(244)	53	297	1,023	1,023	0
STF	140	140	0	1,394	1,394	0
Surplus - Total	**(104)**	**193**	**297**	**2,417**	**2,417**	**0**

As in 2016/17, two key components need to be achieved in order to receive STF monies. Referral to Treatment STF can only be received if the financial performance criteria has been met. This is currently ahead of target and therefore will be secured alongside the achievement of the financial performance metric.

Financial Performance	123	123	0	1,220	1,220	0
Referral to Treatment	18	18	0	174	174	0
STF - Total	**140**	**140**	**0**	**1,394**	**1,394**	**0**

Month 2

The normalised year to date position is a surplus of £53k excluding STF and £193k including STF funding. This is £0.3m ahead of plan, the key headlines are below:

In month there have been favourable movements in the financial position resulting in a normalised surplus position for May of £97k. In terms of variance to plan £137k, the key headlines behind this are:

	£k Mth 2	£k YTD	
Income	2	(85)	CQUINs have underachieved by £56k in month 2 £139k YTD, this has been offset by overachivement of non contract activity.
Pay	426	927	Agency and Bank staff continue to be employed by the Trust to meet clinical and service requirements. Actions continue to ensure that the clinical and financial consequences are minimised. These include ongoing recruitment and expansion of the peripatetic staffing model.
	(141)	(236)	Pay overspends are offset by underspends in pay arising from vacancies
Non Pay	(152)	(10)	Overspends are in Drugs (M2 £60k, YTD £146k), Clinical Supplies (M2 £66k, YTD £78k) and out of area (M2 £164k, YTD £277k), offset by underspends on non clinical areas such as Travel and Office supplies. Recoding of the Apprentice levy (£103k) from Provisions to Non Pay also impacted on the variance.
	26	(284)	Provisions, and budgets held centrally.
	(23)	(13)	Depreciation and PDC are in line with planned expenditure
	137	**297**	

Forecast

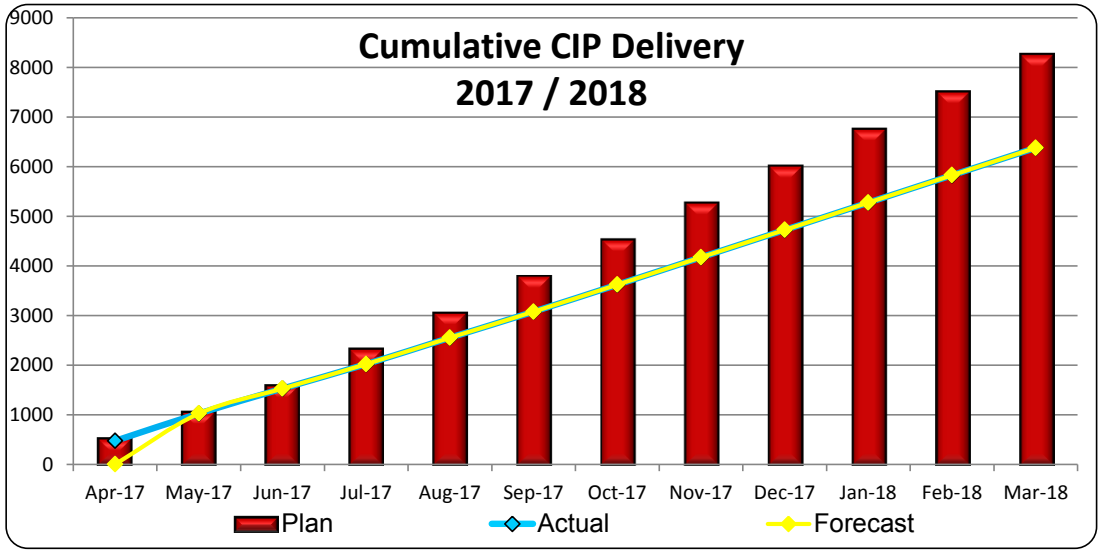
The full year STF income is currently forecast to achieve plan but there remains some risk attached with its delivery. These risks, and also any opportunities, continue to be assessed to ensure that the plan is delivered.

The CQUIN performance risk is £1m, of which £0.8m relates to achievement of STP control total

A full review of year-end forecast, risks and opportunities is scheduled to take place in early July in time for reporting to the July Trust Board.

2.1 Cost Improvement Programme 2017 / 2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Cumulative	537	1,074	1,610	2,341	3,072	3,809	4,546	5,283	6,021	6,768	7,515	8,262	1,074	8,262
Delivery as originally planned	404	849	1,272	1,709	2,184	2,667	3,170	3,680	4,190	4,699	5,209	5,720	849	5,720
Mitigations - Recurrent & Non-Recurrent	68	174	255	311	368	409	451	493	535	577	619	661	174	661
Total Delivery	**472**	**1,024**	**1,527**	**2,020**	**2,552**	**3,077**	**3,621**	**4,173**	**4,725**	**5,276**	**5,828**	**6,380**	**1,024**	**6,380**
Shortfall / Unidentified	65	50	83	321	521	733	925	1,111	1,296	1,491	1,686	1,882	50	1,882



The Trust identified a CIP programme for 2017 / 2018 which totals £8.3m. This included £1.6m of unidentified savings for which specific schemes need to be defined and delivered.

This gap is being addressed through specific projects with identified Director leads and progress is monitored through the Trust Operational Management Group (OMG).

To date all operational BDU schemes have been delivered as planned (or successfully mitigated against with alternatives). Schemes, to date, currently rated as red related to reduced training budgets and procurement savings.

The forecast red schemes are increased by the unidentified CIP gap. Schemes and themes are being worked through and will reduce the red value in future months.

3.0 Balance Sheet 2017 / 2018

	2016 / 2017 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	111,199	112,565	113,518	1
Current Assets				
Inventories & Work in Progress	166	215	166	
NHS Trade Receivables (Debtors)	2,138	1,999	807	2
Other Receivables (Debtors)	8,289	6,889	12,152	3
Cash and Cash Equivalents	26,373	24,845	21,467	4
Total Current Assets	**36,966**	**33,948**	**34,591**	
Current Liabilities				
Trade Payables (Creditors)	(7,213)	(6,634)	(6,191)	5
Capital Payables (Creditors)	(1,157)	(752)	(996)	5
Accruals	(9,912)	(11,473)	(10,870)	6
Deferred Income	(754)	(950)	(874)	
Total Current Liabilities	**(19,036)**	**(19,809)**	**(18,932)**	
Net Current Assets/Liabilities	**17,929**	**14,139**	**15,660**	
Total Assets less Current Liabilities	**129,128**	**126,704**	**129,178**	
Provisions for Liabilities	(7,550)	(7,763)	(7,406)	
Total Net Assets/(Liabilities)	**121,578**	**118,941**	**121,771**	
Taxpayers' Equity				
Public Dividend Capital	43,665	43,665	43,665	
Revaluation Reserve	18,766	18,413	18,766	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,928	51,643	54,121	7
Total Taxpayers' Equity	**121,578**	**118,941**	**121,771**	

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

1. Capital expenditure is detailed on page 9.The value of fixed assets includes additions, disposals and depreciation charges.

2. NHS debtors are currently lower than plan primarily due to accrued income being higher than planned. Information has now been received allowing the larger invoices to now be raised.

3. Other debtors are higher than planned which includes STF income relating to 2016 / 2017 (c. £2m). This is expected to be received in July 2017.

4. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 11.

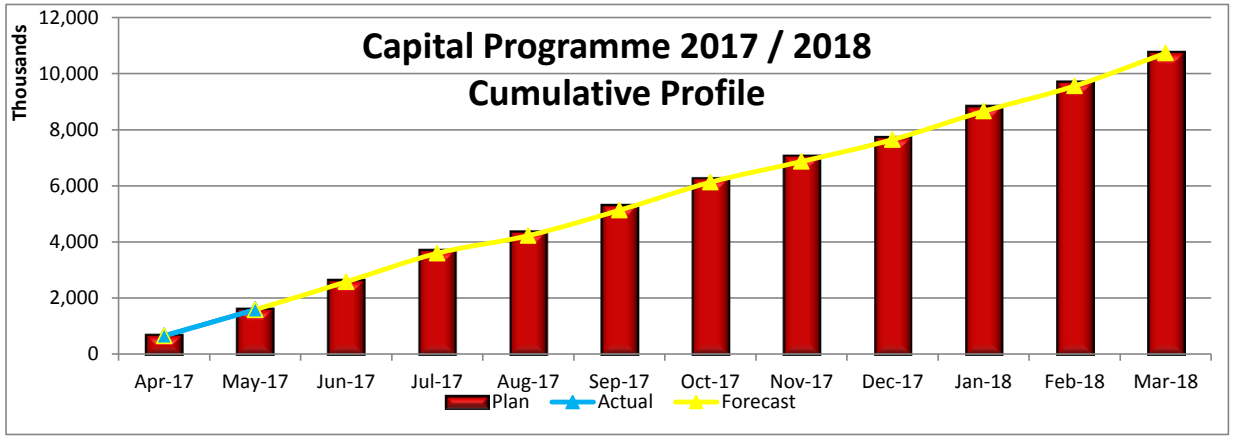
5. Overall creditors are lower than planned with payments continuing to be made in a timely fashion to support the Trust Better Payment Practice Code. Since the end of the financial year work is ongoing to clear old invoices.

6. Accruals are lower than planned. Work is on-going to validate accruals ahead of the quarter end.

7. This reserve represents year to date surplus plus reserves brought forward.

3.1 Capital Programme 2017 / 2018

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	1,558	200	101	(99)	1,568	10	4
Equipment Replacement	44	0	0	0	44	(0)	
IM&T	2,121	56	30	(26)	2,121	0	
Major Capital Schemes							
Fieldhead Non Secure	7,030	1,390	1,475	85	7,030	(0)	3
VAT Refunds	0	0	(28)	(28)	(28)	(28)	
TOTALS	**10,753**	**1,646**	**1,578**	**(68)**	**10,734**	**(19)**	2



Capital Expenditure 2017 / 2018

1. The Trust capital programme for 2016 / 2017 is £10.8m and schemes are guided by the current Trust Estates Strategy.

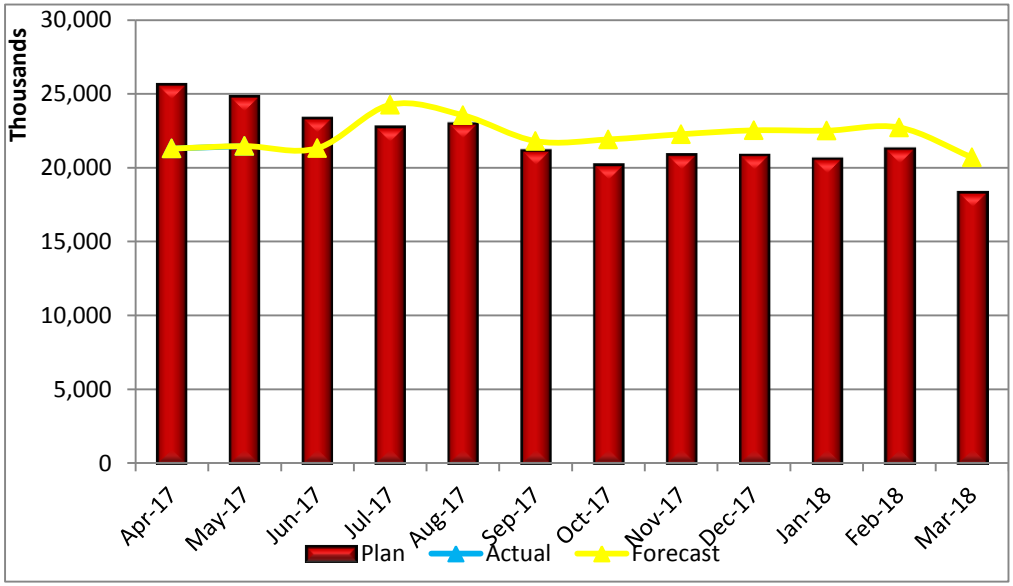
2. The year to date position is £68k behind plan (4%). Excluding the benefit from arising from successful VAT recovery agreed with HMRC this is £40k behind plan.

Progress continues to be reviewed and discussed including through the Trust Estates TAG.

3. Phase 1 of the Fieldhead Non-Secure project is due to be completed and open early August 2017. Phase 2 will commence immediately afterwards.

4. Small schemes, behind plan to date, mainly relate to 2 Nehaven schemes (clinic rooms and boundaries).

3.2 Cash Flow & Cash Flow Forecast 2017 / 2018



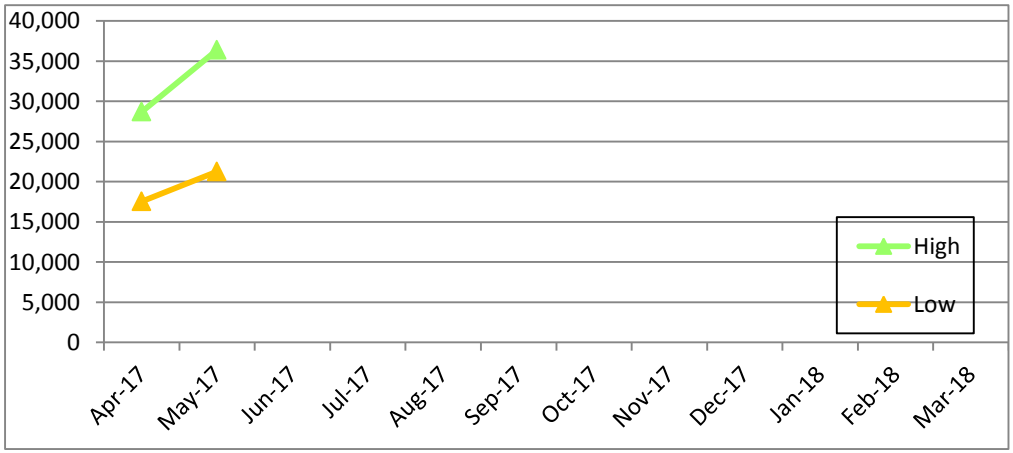
	Plan £k	Actual £k	Variance £k
Opening Balance	25,495	26,373	
Closing Balance	24,845	21,467	(3,378)

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

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

Cash is lower than planned in month. Block contract income has now been invoiced and it is expected that the STF funding will be paid in July 2017 to bolster the Trust cash position.

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



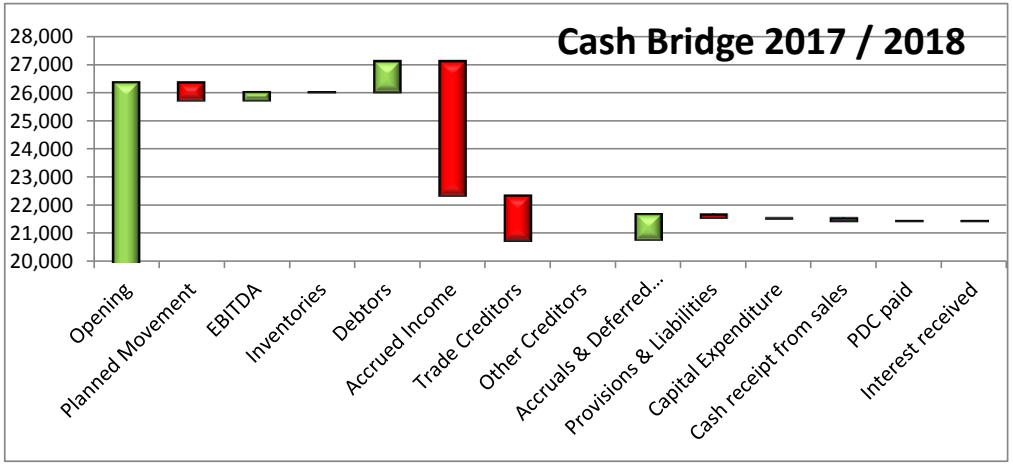
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£36.4m
The lowest balance is:	£21.3m

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

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**25,495**	**26,373**	878	1
Surplus (Exc. non-cash items & revaluation)	1,472	1,780	308	2
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	0	1,097	1,097	3
Accrued Income / Prepayments	(633)	(5,397)	(4,764)	5
Trade Payables (Creditors)	0	(1,588)	(1,588)	6
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	150	1,079	929	4
Provisions & Liabilities	0	(144)	(144)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,647)	(1,740)	(93)	
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	8	6	(2)	
Closing Balances	**24,845**	**21,467**	**(3,378)**	



The plan value reflects the March 2017 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. Brought forward cash position was higher than planned.

2. Surplus position marginally higher than planned.

3. Debtors are lower than plan due to timely chasing of debt.

4. Accruals higher than planned as invoices are awaited. We are still awaiting a number of high value invoices from a number of suppliers.

Factors which decrease the cash position against plan:

5. Accrued income continues to be higher than plan, this includes the 2016/17 STF funding which is expected to be paid in July 2017 and the Barnsley Alliance contract which has been invoiced in June 2017.

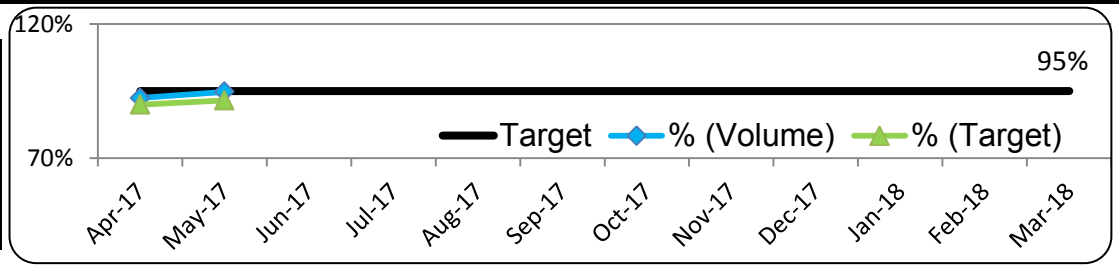
6. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

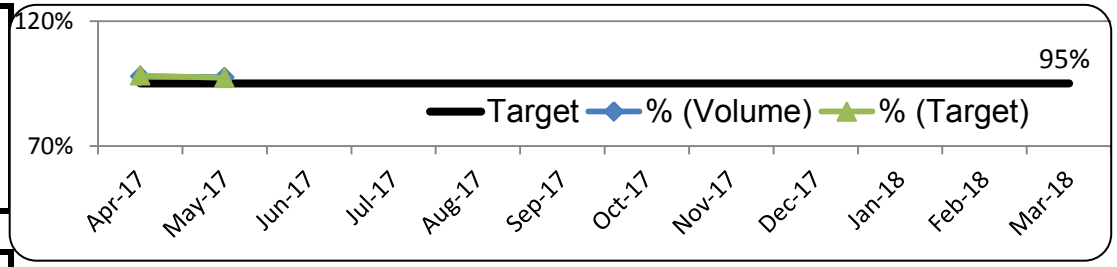
4.0 Better Payment Practice Code

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

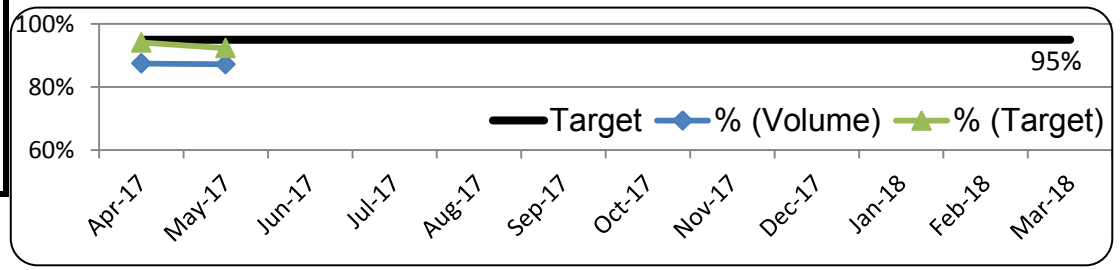
NHS	Number %	Value %
Year to April 2017	92%	90%
Year to May 2017	95%	91%



Non NHS	Number %	Value %
Year to April 2017	98%	98%
Year to May 2017	97%	97%



Local Suppliers (10 days)	Number %	Value %
Year to April 2017	87%	94%
Year to May 2017	87%	92%



4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

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

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

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
16-May-17	Lease Rent	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3035084	209,476
24-Apr-17	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3033226	65,361
07-Apr-17	Staff Recharge	Barnsley	Barnsley Metropolitan Borough Council	3031609	61,014
01-May-17	CNST contributions	Trustwide	NHS Litigation Authority	3034112	47,581
15-May-17	CNST contributions	Trustwide	NHS Litigation Authority	3035025	47,581
12-May-17	Lease Rent	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3034905	39,372
01-Feb-17	Minor Works	Wakefield	Mid Yorkshire Hospitals NHS Trust	3024309	25,809

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2016 / 2017 the Trust were set a control total surplus.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.70%	4.80%	4.90%	4.90%	4.60%	4.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.60%	5.90%	5.80%	5.20%	4.60%	4.50%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.00%	95.00%	95.50%	96.60%	7.00%	24.00%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.10%	94.60%	95.30%	96.00%	3.20%	8.20%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.10%	82.30%	77.60%	76.20%	77.50%	71.90%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.90%	82.40%	82.50%	81.30%	81.90%	79.10%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	70.80%	75.50%	78.20%	77.90%	76.00%	74.70%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.70%	88.60%	89.40%	89.00%	88.20%	88.50%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.60%	86.20%	82.60%	81.50%	78.80%	80.80%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	81.30%	80.70%	80.30%	79.60%	77.50%	76.10%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.40%	88.80%	87.80%	86.70%	86.40%	87.10%
Information Governance	Resources	Well Led	AD	>=95%	87.50%	91.80%	94.90%	95.40%	91.30%	89.80%
Moving and Handling	Resources	Well Led	AD	>=80%	80.60%	82.20%	83.70%	82.80%	83.10%	81.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	91.90%	90.60%	90.40%	89.90%	89.50%	89.30%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	90.30%	88.90%	88.40%	88.20%	88.00%	86.50%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.10%	98.20%	97.40%	95.70%	94.70%	94.60%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	45.00%	47.10%	51.50%	55.90%	54.60%	56.90%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	33.70%	34.40%	38.30%	42.90%	44.60%	41.20%
Agency Cost	Resources	Effective	AD		£190k	£148k	£143k	£115k	£92k	£109k
Overtime Costs	Resources	Effective	AD		£6k	£6k	£4k	£4k	£7k	£3k
Additional Hours Costs	Resources	Effective	AD		£26k	£18k	£23k	£25k	£32k	£20k
Sickness Cost (Monthly)	Resources	Effective	AD		£191k	£179k	£167k	£167k	£132k	£136k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		133.76	133.8	136.67	131.92	111.33	108
Business Miles	Resources	Effective	AD		112k	107k	101k	102k	108k	91k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.90%	4.90%	5.00%	5.00%	4.60%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.50%	5.30%	5.10%	4.90%	4.60%	4.80%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.50%	98.50%	98.20%	98.50%	3.00%	14.90%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	93.80%	95.30%	95.80%	96.50%	0.80%	2.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.30%	77.40%	77.40%	75.80%	74.30%	72.30%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	66.70%	70.10%	72.10%	72.80%	75.20%	75.40%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	57.60%	63.80%	65.80%	69.40%	72.40%	71.30%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.70%	89.00%	89.70%	86.50%	86.20%	84.50%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.80%	80.20%	81..7%	80.90%	81.10%	80.50%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	81.30%	79.20%	79.10%	78.70%	79.60%	78.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	79.00%	78.20%	78.30%	78.90%	78.00%	78.80%
Information Governance	Resources	Well Led	AD	>=95%	86.60%	94.50%	96.70%	97.50%	92.80%	92.60%
Moving and Handling	Resources	Well Led	AD	>=80%	75.80%	77.40%	79.50%	79.80%	79.30%	76.10%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.70%	90.40%	89.60%	88.60%	87.40%	86.80%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.30%	85.30%	84.20%	83.70%	83.00%	82.80%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.60%	96.40%	95.90%	95.80%	95.50%	93.30%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	30.80%	33.30%	39.60%	58.00%	61.10%	75.40%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	19.80%	22.70%	30.30%	49.40%	52.30%	67.10%
Agency Cost	Resources	Effective	AD		£228k	£173k	£177k	£165k	£76k	£61k
Overtime Costs	Resources	Effective	AD		£6k	£9k	£5k	£3k	£3k	£3k
Additional Hours Costs	Resources	Effective	AD		£0k	£1k	£1k	£1k	£1k	£-2k
Sickness Cost (Monthly)	Resources	Effective	AD		£84k	£93k	£97k	£112k	£111k	£115k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		50.95	50.69	47.64	40.79	85.41	75.52
Business Miles	Resources	Effective	AD		75k	58k	54k	57k	62k	58k

Appendix - 2 - Workforce - Performance Wall cont…

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	6.20%	6.40%	6.40%	6.4%	7.00%	6.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	8.20%	8.00%	6.80%	6.2%	7.00%	5.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	92.00%	92.20%	93.70%	93.7%	10.30%	21.2%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	77.80%	82.50%	88.50%	90.0%	1.70%	7.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.70%	85.40%	83.40%	84.5%	85.80%	85.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	53.10%	60.50%	62.60%	66.6%	68.30%	74.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	10.50%	26.70%	45.10%	50.8%	54.70%	65.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	90.80%	91.90%	92.30%	92.0%	89.20%	86.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.80%	84.60%	85.40%	86.7%	85.90%	83.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.00%	87.10%	86.70%	88.0%	89.20%	88.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.90%	81.50%	82.70%	82.2%	81.70%	84.9%
Information Governance	Resources	Well Led	AD	>=95%	85.20%	90.90%	95.50%	97.6%	91.50%	92.7%
Moving and Handling	Resources	Well Led	AD	>=80%	84.40%	85.50%	85.40%	87.2%	84.90%	82.9%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.00%	90.90%	92.10%	92.3%	92.30%	91.7%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.30%	87.90%	87.60%	87.8%	88.40%	87.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	78.90%	82.40%	93.80%	80.0%	75.00%	51.7%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	29.10%	33.80%	42.40%	65.4%	65.70%	70.7%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	14.20%	18.50%	30.10%	55.8%	56.00%	61.9%
Agency Cost	Resources	Effective	AD		£95k	£114k	£128k	£95k	£58k	£54k
Overtime Costs	Resources	Effective	AD		£9k	£-1k	£0k	£3k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£0k	£1k	£5k	£2k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£63k	£81k	£53k	£54k	£62k	£47k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		37.55	46.25	49.44	50.20	49.29	47.49
Business Miles	Resources	Effective	AD		8k	5k	15k	9k	8k	5k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.80%	4.90%	5.00%	5.00%	5.40%	5.80%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.60%	5.80%	6.40%	5.70%	5.50%	5.70%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	82.70%	84.30%	87.40%	87.50%	3.80%	9.40%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	62.50%	66.70%	70.30%	71.20%	0.60%	1.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.60%	73.10%	72.00%	72.30%	72.70%	75.20%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	65.70%	71.50%	71.80%	70.40%	70.70%	69.20%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	28.60%	33.20%	38.10%	39.70%	43.50%	46.50%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.90%	89.10%	88.30%	87.40%	85.70%	84.80%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.90%	80.40%	79.50%	80.10%	78.60%	80.20%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	60.00%	58.30%	62.50%	60.00%	59.10%	56.50%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.40%	86.30%	86.50%	85.90%	84.40%	83.30%
Information Governance	Resources	Well Led	AD	>=95%	84.20%	92.70%	96.00%	97.30%	92.80%	91.50%
Moving and Handling	Resources	Well Led	AD	>=80%	80.70%	80.90%	80.90%	77.00%	75.70%	75.80%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	85.90%	85.20%	83.80%	83.00%	82.10%	82.40%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.90%	88.10%	87.30%	84.70%	86.80%	85.20%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	88.50%	89.30%	87.80%	87.90%	87.80%	86.90%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	28.90%	31.60%	37.50%	55.60%	58.30%	62.70%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	9.50%	11.70%	17.50%	42.70%	54.70%	57.80%
Agency Cost	Resources	Effective	AD		£185k	£88k	£165k	£261k	£178k	£167k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£3k	£2k	£2k	£3k
Additional Hours Costs	Resources	Effective	AD		£5k	£3k	£4k	£5k	£5k	£4k
Sickness Cost (Monthly)	Resources	Effective	AD		£40k	£48k	£69k	£74k	£64k	£78k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		75.78	71.96	64.87	57.42	53.47	51.56
Business Miles	Resources	Effective	AD		40k	38k	38k	31k	39k	33k

Appendix 2 - Workforce - Performance Wall cont…

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.60%	4.70%	4.70%	4.8%	4.00%	4.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	6.10%	5.60%	5.40%	4.8%	4.00%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	91.60%	92.10%	92.20%	93.7%	7.10%	17.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	89.90%	94.30%	95.30%	95.5%	0.20%	1.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	64.10%	64.80%	68.70%	71.1%	68.60%	73.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	90.90%	84.80%	90.90%	86.5%	86.10%	86.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	20.0%	100.00%	16.7%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.80%	87.10%	87.90%	87.8%	87.50%	86.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.00%	84.90%	84.90%	85.9%	87.70%	87.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.50%	98.40%	98.40%	96.8%	99.20%	98.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	82.20%	83.20%	83.90%	84.8%	85.50%	86.0%
Information Governance	Resources	Well Led	AD	>=95%	89.20%	89.10%	93.00%	93.4%	92.20%	93.4%
Moving and Handling	Resources	Well Led	AD	>=80%	79.70%	82.60%	85.90%	85.8%	85.80%	72.6%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.40%	89.70%	89.70%	92.9%	93.70%	89.8%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.80%	90.80%	91.00%	90.9%	90.90%	86.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	20.0%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	90.10%	91.00%	91.60%	92.90%	93.70%	94.8%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	16.30%	19.10%	29.80%	33.3%	38.80%	53.1%
Agency Cost	Resources	Effective	AD		£40k	£32k	£26k	£33k	£8k	£5k
Overtime Costs	Resources	Effective	AD		£2k	£1k	£1k	£0k	£5k	
Additional Hours Costs	Resources	Effective	AD		£11k	£18k	£16k	£13k	£14k	£8k
Sickness Cost (Monthly)	Resources	Effective	AD		£79k	£99k	£73k	£84k	£66k	£81k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		58.56	60.89	55.36	52.39	23.23	43.12
Business Miles	Resources	Effective	AD		46k	40k	47k	39k	40k	29k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.00%	5.30%	5.50%	5.40%	5.50%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	6.40%	8.00%	7.70%	6.00%	5.50%	4.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.30%	94.60%	95.20%	94.60%	2.10%	16.10%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	87.60%	89.00%	88.80%	91.00%	4.40%	11.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.30%	80.80%	82.60%	80.40%	81.10%	80.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	56.20%	60.40%	61.30%	62.60%	65.00%	69.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	52.30%	57.10%	60.60%	59.70%	63.40%	61.50%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.40%	91.00%	89.60%	87.10%	86.00%	86.80%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.70%	86.00%	84.10%	83.10%	78.90%	80.90%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.00%	77.90%	76.50%	75.20%	76.70%	75.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	78.80%	78.70%	78.50%	78.40%	77.80%	77.10%
Information Governance	Resources	Well Led	AD	>=95%	81.80%	92.30%	95.50%	97.20%	91.80%	92.30%
Moving and Handling	Resources	Well Led	AD	>=80%	71.10%	73.10%	72.20%	75.00%	72.60%	71.30%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.00%	88.70%	88.40%	87.50%	86.40%	85.30%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	80.40%	82.30%	80.70%	79.40%	77.90%	77.40%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.00%	94.90%	95.20%	93.10%	93.50%	92.50%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	33.00%	34.00%	40.90%	57.60%	59.30%	59.10%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	25.60%	26.50%	33.40%	49.30%	50.30%	49.70%
Agency Cost	Resources	Effective	AD		£146k	£107k	£91k	£164k	£88k	£31k
Additional Hours Costs	Resources	Effective	AD		£5k	£2k	£3k	£3k	£2	£4k
Sickness Cost (Monthly)	Resources	Effective	AD		£68k	£75k	£67k	£69k	£64k	£46k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		75.44	68.48	69.36	64.28	50.56	48.56
Business Miles	Resources	Effective	AD		35k	36k	32k	34k	32k	29k

Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoC	Duty of Candour
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View
HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
ICD10	International Statistical Classification of Diseases and Related Health Problems
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
OOA	Out of Area
OPS	Older People's Services
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
4	On-target to deliver actions within agreed timeframes.
3	Off trajectory but ability/confident can deliver actions within agreed time frames.
2	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
1	Actions/targets will not be delivered
	Action Complete

NB: The Trusts RAG rating system was reviewed by EMT during October 16 and some amendments were made to the wording and colour scheme.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27June 2017
Agenda item 6.1

Title:	**Incident management annual report 2016/17**
Paper prepared by:	Director of Nursing and Quality
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee.
Executive summary:	**Clinical Governance & Clinical Safety Committee (CGCS) review**: The incident report has been scrutinised at CGCS which was supported by a presentation of the report by the Assistant Director of Patient Safety (attached). The Committee commented that: ➢ The report was of high quality and well structured. ➢ The incident data within the report was within the anticipated range for an organisation of this size. ➢ The Committee took assurance from the associated internal audit report on our SI process which showed significant assurance with minor improvements and mirrors the recent Care Quality Commission (CQC) reports. ➢ Reporting trends have continued to increase from previous years which is an indication of a positive reporting culture. ➢ The Committee was assured that the report represents an accurate overview of our incident reporting and that the correct systems and processes are in place. ➢ They supported the next steps identified in the report. ➢ The associated learning lessons report be reviewed at the next Committee meeting. **Report highlights** The Trust showed a 5% increase in incidents reported on the previous year. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture (NPSA Seven Steps to Safety). ➢ The number of incidents reported across the Trust has increased although the overall proportion of more serious incidents is a lower proportion of all incidents than last year. The number of apparent suicides has decreased from last year from 41 to 28. This is based on the date when the serious incident was reported, not the date of death. ➢ 54% of the male apparent suicides were under 35. ➢ During 16/17 there have been no 'never events', no homicides. The Trust has been issued with one section 28 from the Coroner. ➢ There were no Trustwide actions arising from the CQC inspections. It was

noted in the report (2017) that "…the use of the Datix electronic incident recording system was used across the trust in a variety of different arenas, and across wards and services, to identify trends/areas of concern that need to be addressed".

- The report makes reference to the learning that takes place when an incident occurs. Further details of this work is described in "Our Learning Journey" report.
- The Trust continues to implement and monitor the Patient Safety Strategy, including national Sign up to Safety initiative, ensuring duty of candour is embedded and monitored, and developing ways of capturing and sharing lessons learned. In support of the Strategy, the Trust continues to implement and monitor its Suicide Prevention Strategy action plan.
- The Trust has a statutory and contractual duty to be open, honest and transparent in our communication with service users (and/or family/carer) where there has been moderate harm or above. During 2016/17 there were five cases where this was not met. Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown. We are not aware of any fines being imposed for these cases.

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.
- The report has already informed the quality priorities for 17/18 particularly in the safe, effective and caring domains. Key areas include, improved clinical risk assessment and our work on suicide prevention.
- Continue to refine and embed work on analysing sub-themes for serious incident recommendations.
- Support implementation of the patient safety and suicide prevention strategies, including work on culture and implementation of safety huddles
- Continue to work with Mazars and north of England mental health trusts in in response to national learning from deaths requirements, and to review Trust policies in light of this.
- To network with other Trusts across West Yorkshire.

Risk appetite

Risk identified – the trust continues to have a good governance system of reporting and investigating incidents including serious incidents.

This report provides assurance for compliance with health and safety legislation and CQC standards for incident reporting. This meets the risk appetite – low and the risk target 1-3.

The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3. The reporting, investigating and implementing change supports the drive to reduce harm and learn to prevent recurrence of incidents.

Recommendation:	**Trust Board is asked to RECEIVE and COMMENT on the annual incident management report, with the assurance from the Clinical Governance and Clinical Safety Committee and the next steps identified.**
Private session:	Not applicable.

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Incident Management Annual Report 2016/17

Patient Safety Support Team

With **all of us** in mind.

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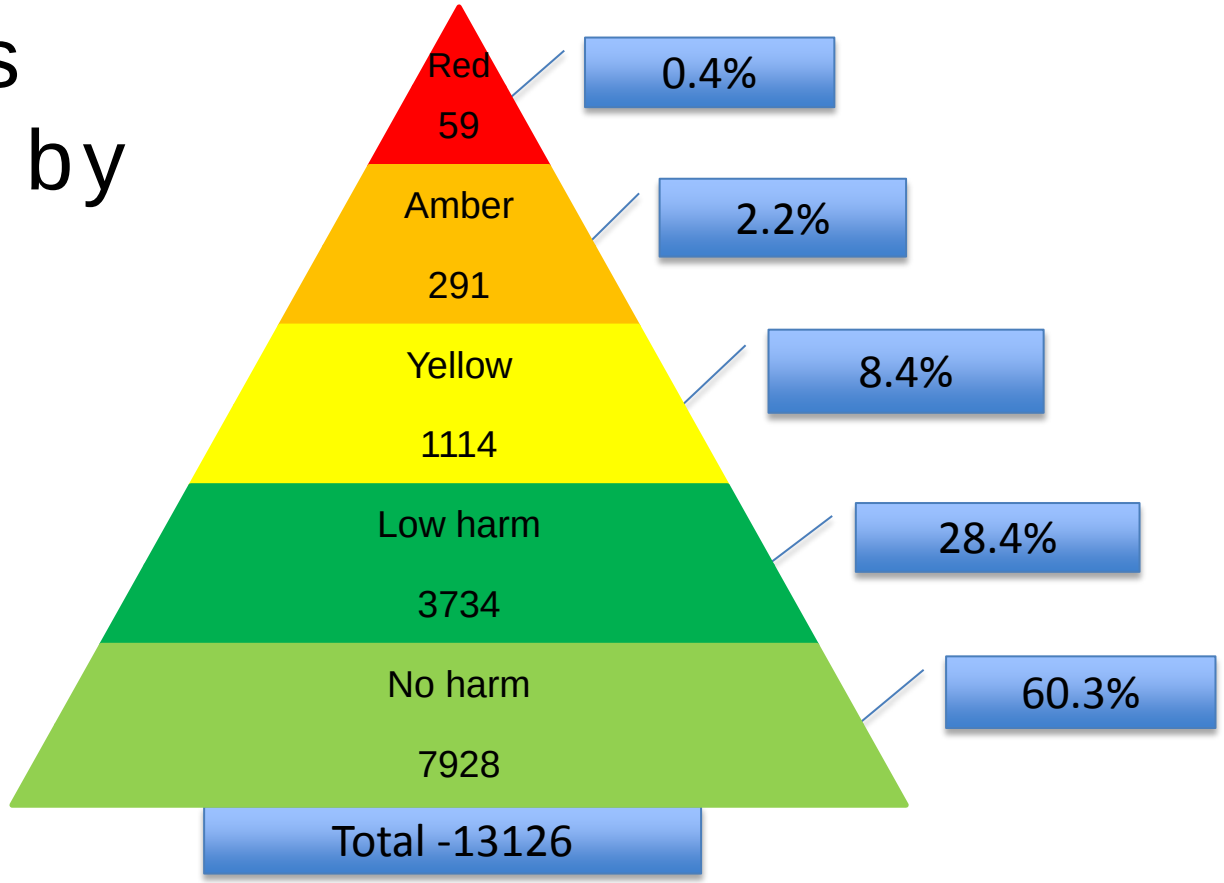
Incidents reported by severity 2016/17



With **all of us** in mind.

Trust Incident Headlines 2016/17

South West Yorkshire Partnership NHS Foundation Trust

- **13126** incidents reported
- **5%** increase in reporting on 2015/16
- **89%** of incidents resulted in no/low harm
- **65** Serious incidents reported in 16/17
- No homicides
- No Never Events*
- Serious Incidents account for **0.4%** of all incidents reported
- Reduction in serious incidents in 2016/17 from 2015/16
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

*Never Events are a specific list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

[1]NPSA. (2004). Seven Steps to Patient Safety

With **all of us** in mind.

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Trust Incident Data 2016/17

- Independent reviews relating to 3 previous homicides occurring in 2010 and 2011 were concluded during 2015/16. The Trust is awaiting closure of two of the action plans. All action plans have been implemented.

- The Trust has also been involved in an independent investigation that took place in a neighbouring locality. This incident took place in 2014 and we are awaiting publication. Actions for the Trust have been completed.

With **all of us** in mind.

Trust Serious Incident Headlines 2016/17

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- 65 Serious incidents reported
- Serious incidents account for 0.4% of all incidents
- Reduction on total for 2015/16 (76)
- Reduction in apparent suicides in 2016/17 (28), compared to 2015/16 (41).
- No homicides
- No Never Events

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South West Yorkshire Partnership NHS Foundation Trust

Trust Incident Data 2016/17

- Serious Incident data over three years

2014/15	106 (34 pressure ulcers)
2015/16	76 (3 pressure ulcers*)
2016/17	65 (6 pressure ulcers)

*The reporting criteria for pressure ulcers changed in February 2015 (to only those attributable to SWYPFT care, and avoidable)

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Analysis of Serious Incidents 2016/17

South West Yorkshire Partnership NHS Foundation Trust

- No cluster in any BDU
- Highest category – suicide/apparent suicide (28);
- Other deaths (8)
- Information Governance breaches (10) [8 information disclosed in error; 1 healthcare records issue; 1 lost stolen paperwork]
- Pressure ulcers (6) (Barnsley General Community)
- Other incidents – self harm (3); V&A (7); fire (1); AWOL (1) and falls (2) NB one fall resulted in death (included in death figures).
- x4 SIs were identified for significant learning/case study and have been closely monitored by CGCS and EMT

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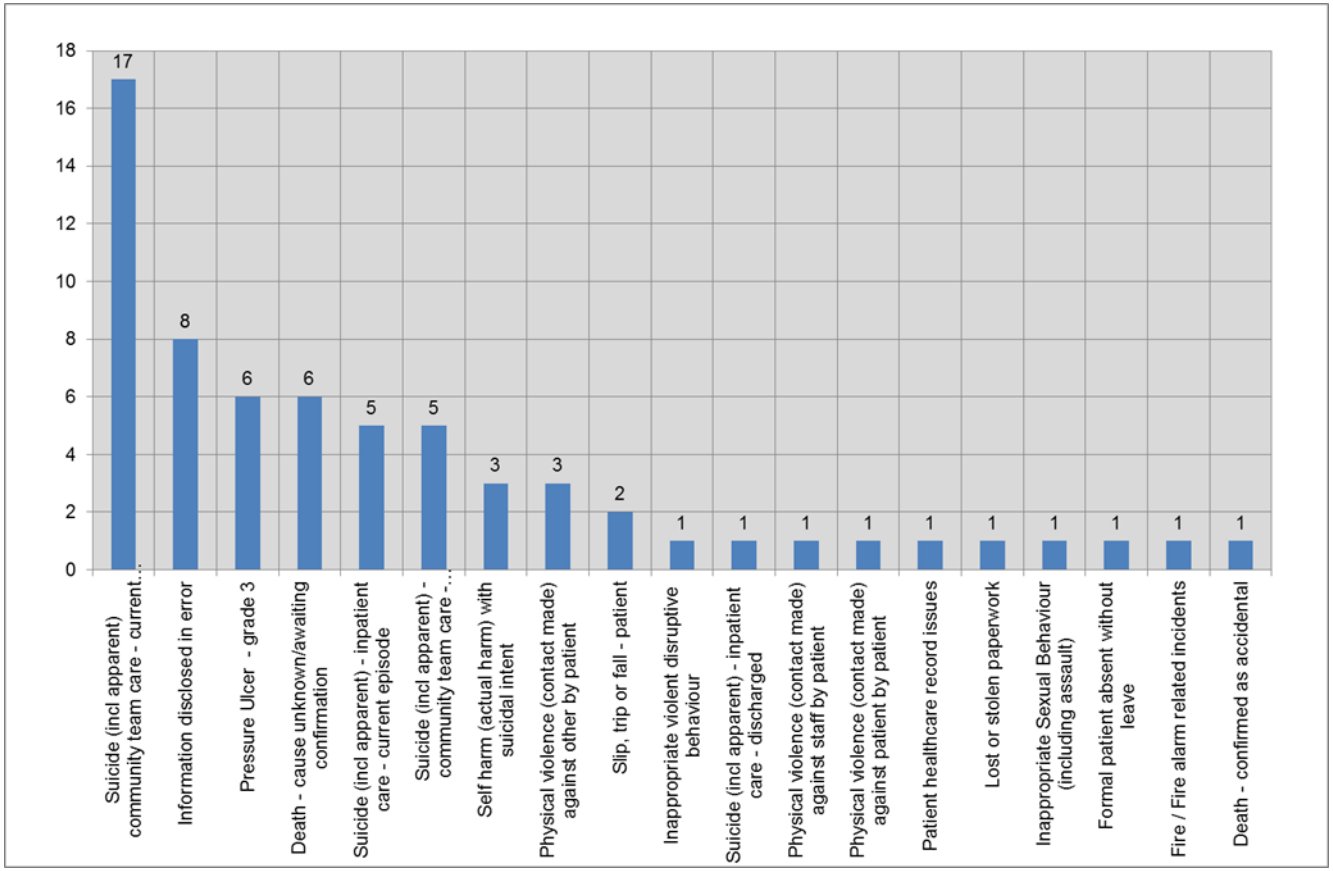
Trust Serious Incidents 2016/17 by category breakdown



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Apparent suicides 2016/17 Headlines

South West Yorkshire Partnership NHS Foundation Trust

- Apparent suicide total is lower than last year with 28 deaths being reported 2016/17, 41 deaths reported last year
- Apparent suicides lower than national figures would suggest. 28 deaths rather than suggested figures 34
- Of the 26 apparent suicides of males, 54% are under 35
- Apparent suicide of females is much lower than national figures would suggest. 2 deaths rather than suggested 9 deaths.

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Analysis of apparent suicides 2016/17

NHS
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- Highest category – suicide/apparent suicide (28)
- Data is based on the incident reported not the coroner's verdict, and may change
- Most common method is hanging (46%), 43% nationally
- 78% were in contact with trust services at the time of their death
- Based on an average of the suicides recorded in the general population between 2004 to 2014, there are approximately 10.2 (West Yorkshire STP) and 9.8 (South Yorkshire & Bassetlaw) suicides per 100,000 general population each year.
- On average during 2004-2014 patient suicides accounted for 28% of the general population suicide figures
- Kirklees is slightly above its expected range; Barnsley has the expected number; Wakefield and Calderdale are below the suggested range.
- Trust wide, the 4 year average apparent suicides is 33.75, consistent with the suggested range (33-34)

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Analysis of apparent suicides 2016/17

District	Population ONS – population estimates Mid 2015	General population suicide rate (NCI) 10.1 per 100,000	Patient suicide rate (28% general pop) (NCI)	Apparent suicide reported on STEIS 2015/16	Apparent suicide reported on STEIS 2016/17	Mental health service users with 1 or more contacts 2016/17	Apparent suicide figures per 10,000 MH contacts
Barnsley	239,319	23	6-7	6	6*	13163	3.8
Calderdale	208,402	21	6	4	2	5712	3.5
Kirklees	434,321	44	12	19	14**	15922	7.5
Wakefield	333,759	34	9-10	11	6***	9432	5.3
Trust-wide	1,215,801	122	33-34	40	28	**44229**	5.4

**includes 1 ADHD service apparent suicide*
***includes 2 CAMHS apparent suicides (NB one subsequently changed to natural causes, as comment on Figure 13)*
****includes 1 Forensic service apparent suicide (patient from Wakefield area)*

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Trust Serious Incident Investigations completed 2016/17

South West Yorkshire Partnership NHS Foundation Trust

61 serious incident investigations completed

13 investigations had no recommendations

163 recommendations made

Top 3 recommendation themes:

1) Record keeping
2) Staff education, training and supervision
3) Communication

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Ordinal list of recommendations 2016/17 and 2015/16

Top 6 Recommendation theme	2016/17	2015/16
A5 Record keeping	1	2
F1 Staff education, training and supervision	2	6
B1 Communication	3	
A1 Care pathway	4	
A2 Care delivery	5	3
G1 Organisational systems, management issues	joint 6	1
F4 Team/service systems, roles and management	joint 6	6

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External review

- Serious Incident Investigation reports are quality assured by commissioners
- Many positive comments have been received regarding the quality and depth of the reports.

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Duty of Candour

- Duty of Candour became a statutory requirement in November 2014 for health providers. The patient safety support team has been reporting to CCGs from April 2014.
- Any patient safety incident that resulted in moderate harm or above meets the requirement
- During 2016/17 a project manager was responsible for monitoring compliance with Duty of Candour
- 308 incidents were applicable in 2016/17 (2.3% of all incidents reported).

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Duty of Candour

- 87% were completed within 10 days (268)

Exceptions

- 11 were completed, but after the 10 day timeframe (3.5%) these are marked as exceptions.
- 11 not completed but exception reasons were given and accepted (3.5%).

Breaches

- In 5 cases, Duty of Candour was not documented on Datix and no rationale was given (0.3%)
- 4 self harm - 3 C&K; 1 CAMHS [CAMHS subsequently updated that DOC was not appropriate];
- 1 pressure ulcer - Barnsley district nursing
- Multiple reminders to team managers by DOC project manager.
- No known fines incurred but potential for £50k

Other

- 13 where information was not provided to make a decision. These may include breaches

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Key Developments in 2016/17 included:

- Supported development and coordination of the Patient Safety Strategy and associated implementation plans eg Sign up to Safety, Suicide prevention strategy, national kitchen table event.
- Introduced feedback option to reporters to aid closing the loop
- Continued development of serious incident processes
- Continued support for BDU learning event forums
- Worked closely with Mazars on learning from deaths
- Developed processes and Datix to support mortality requirements

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South West Yorkshire Partnership NHS
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 6.2

Title:	**Customer Services Annual Report 2016/17**
Paper prepared by:	Director of Corporate Development
Purpose:	To note feedback on experience of using Trust services received via the Customer Services function during 2016/17, the themes arising, learning, and action taken in response to feedback. To note also the summary Friends and Family Test results and comments and the number and types of requests received by the Trust under the Freedom of Information Act.
Mission/values:	A positive service user experience underpins the Trust's mission and all its values. The Trust is open and transparent in responding to requests for information under the Freedom of Information (FOI) Act.
Any background papers/ previously considered by:	Trust Board approves Customer Services Policy; with a review at this Board meeting of an update to include information about how to make a complaint direct to the Care Quality Commission in line with the Mental Health Act code of practice. The Board also reviews feedback received via the Customer Services function on a quarterly basis. Trust Board reviews key performance indicators on complaints management in the Integrated Performance Report. Work is currently underway to improve the number of complaints closed within 40 days and to ensure Business Delivery Units (BDUs) ensure action plans arising from complaints investigation are delivered. An improved toolkit has been introduced to assist investigators in answering all the questions and identifying learning, and to promote faster turnaround times for response letters in the checking process. A 'paper-light' process is also being introduced at director level to support complaints sign-off, with increased scrutiny to ensure: ➢ Ownership of the response by the service ➢ Quality assurance of the response in terms of addressing the root causes ➢ Actions are consistently learned and applied across services and in the system. Fortnightly reporting to BDUs enables increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to ensure service improvement in response to feedback. Feedback on compliments received is also shared via the Trust's intranet with the most common themes being praise for the care, support and compassion showed by staff. The customer services team continue to promote the function through leaflets and posters. The team also work with services to encourage signposting to Customer Services as a single gateway to raise issues with the Trust.

Executive summary:	**Customer Services Annual Report 2016/17** This report provides information on feedback received through Customer Services, the themes indicated, lessons learned and action taken in response to feedback. There were 215 formal complaints in the year and 647 compliments. 510 comments and concerns were raised in addition to formal complaints and the Trust received 381 requests under the Freedom of Information Act. Most complaints contain a number of issues; the most frequently raised issues were communication, values and behaviours, care, access, treatment and admission and discharge. **Key areas to note:** ➢ There was an increase in feedback compared to the previous year. ➢ The number of formal complaints decreased by 37% compared to 2015/16, with people being supported to resolve their issues at service level. ➢ There was a significant increase in comments and concerns (up 45% on the previous year) as a consequence of complaints being dealt with at service level. ➢ 647 compliments were shared with Customer Services from across services; slightly less than the previous year. The team is promoting the importance of submitting compliments so that they can be formally acknowledged and best practice shared. The most common theme in compliments is praise for staff. ➢ Work is required to improve the timeliness of complaint responses. This is subject to on-going monitoring. The revised toolkit is supporting quality investigations to enable the preparation of detailed and complete responses for director sign-off. The introduction of a paper-light process at director sign-off is intended to simplify and speed up the sign-off process. There is no national target for local resolution of complaint responses but timely response is important in line with Trust values. ➢ A workshop is planned with the Trust's Quality Improvement Group to review how learning from feedback and incidents is embedded into clinical and operational practice. This will be facilitated at director level, supported by the Integrated Change Team. ➢ The Parliamentary and Health Service Ombudsman (PHSO) was requested to review 9 complaints during the year. The Trust received feedback on 9 cases with action plans resulting in 5 cases, all of which have been delivered. The Executive Management Team reviews action plans arising from PHSO decisions in respect of upheld and partially upheld complaints. ➢ The Trust results for the Friends and Family Test in 2016/17 showed 73% of people using mental health services who completed the Test would recommend them, with 98% recommending community health services. BDUs respond to feedback. ➢ The Trust responded to 381 requests for information under the FOI Act. Requesters are directly to the publication scheme where possible, complex requests are responded to with information owners and exemptions applied where applicable. This information is shared with BDUs for review. Responding to feedback and ensuring changes in practice is monitored through BDU governance processes.

	This report will also be shared with The Members' Council, Commissioners and Healthwatch. **Risk Appetite** This report provides information to the Board on feedback received about Trust services. Issues are escalated to the medical and nursing director and to the relevant service director to ensure action in line with the Trust's Risk Appetite Statement. Any significant risks would be included in BDU risk registers and in the organisational risk register if appropriate. ➢ Complaint responses are reviewed by the investigator, by general managers and service directors and signed off by the Chief Executive. Delivery of action plans in response to learning from feedback is monitored by BDUs and overseen by service directors.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in the financial year 2016/17.**
Private session:	Not applicable.

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NHS Foundation Trust

Customer Services – Annual Report 2016 - 2017

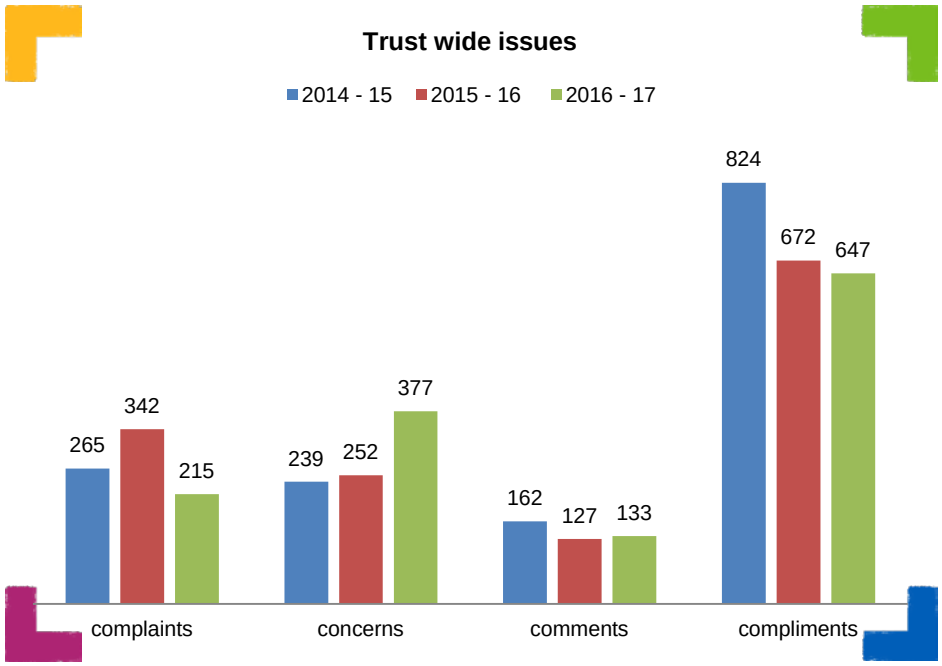
With **all of us** in mind.

Summary:

- Feedback received through complaints, concerns, comments and compliments totalled **1372 in 2016/17**, a slight **increase** on the previous year's figure of 1356.
- **215** formal complaints were received, a 37% **decrease** on the previous year's total of 342. **178** formal complaints were closed. ***14% were closed within 40 days*** *
- **510** comments/concerns were received. This is an 45% **increase** *on the previous year's total of **379.**
- **647** compliments were received (672 in 2015/16). The team is promoting the importance of submitting compliments so that they can be formally acknowledged and best practice shared.
- **728** general enquires were responded to in the year in addition to 4C's management. Sign-posting to Trust services was the most frequent enquiry. **1436** staff contacts were recorded.
- **Communication** was identified as the most frequently raised negative issue (66)**.** This was followed by **values and behaviours (staff)**** (55), **patient care** (53), **access to treatment or drugs** (50) , **clinical treatment** (36), and **admission and discharge** (31). [Most complaints contained a number of themes].
- **73%** of people using mental health services across the Trust who completed the Friends and Family Test said they would recommend them, **98%** would recommend community health services.

**Formal complaint is changed to a concern if, following dialogue, a formal response is not required. (KO41)*

*** further information provided in the report.*

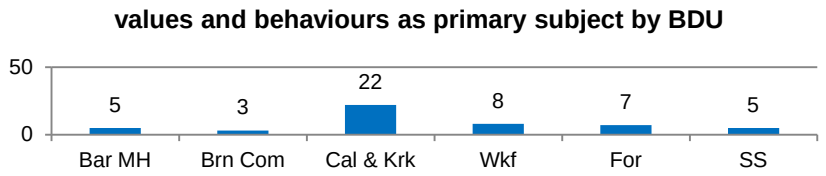


Values and Behaviours (staff)

The Trust received 55 complaints in 2016 -17 that included staff attitude as a factor. Staff attitude was the primary subject matter in 31 complaints and the only factor in 19 complaints.

Across staff groups this related to 26 nurses, 16 consultants, 4 administrative staff other allied health professionals 9.

A further 65 comments and concerns were received which referenced staff attitude but were resolved by the service line to the individual's satisfaction.



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.

The Trust works with partners to ensure the complaints process is as simple and straight forward to access as possible and to ensure a joined up approach to responding to feedback about 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, request additional information from the Trust on occasion and signpost local people to the team to share feedback.

	complaint	concern	comment
Barnsley Hospital NHS Foundation Trust	4	2	0
Barnsley Metropolitan Borough Council	0	1	0
Calderdale and Huddersfield NHS Foundation NHS Trust	1	0	0
Health Watch	1	1	0
Kirklees Council	1	0	0
Mid Yorkshire Hospital NHS Trust	1	2	0
NHS Calderdale CCG	2	1	0
NHS England	1	0	1
NHS Greater Huddersfield CCG	1	0	0
NHS North Kirklees CCG	0	1	0
HMP Wakefield	0	1	0
Sheffield Teaching Hospital	1	0	0
Care Quality Commission	8	3	3
Member of Parliament	13	25	13

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 feedback is posted.

25 individuals posted comments on NHS Choices and Patient Opinion in 2016/17. 5 positive experiences were recorded, 1 related to the Speech and Language Therapy Team in Barnsley and 1 for Priory 2, Wakefield. 3 comments did not identify the service the compliment related to. 20 negative comments were noted, 1 related to Psychology Services, Calderdale & Kirklees and 1 Trinity 2, Wakefield. 18 negative comments did not identify the service the feedback related to.

Feedback is acknowledged with customer services contact details provided should the author wish to discuss their concerns directly with the Trust.

PHSO

At the start of the financial year, 5 cases were with the Parliamentary and Health Service Ombudsman (PHSO) for consideration. In 2016-17, 9 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 2016-17, the Trust received feedback from the Ombudsman regarding 9 cases. 4 were closed with no further action required. 5 cases - Wakefield, adult mental health services, Calderdale and Kirklees CAMHS x 2, Barnsley community mental health services and Kirklees community mental health services were reviewed and partially upheld. Action plans for these cases have subsequently been completed, with learning including ensuring consistent care co-ordination, review of section 117 aftercare training for staff, review of current CPA processes and ensuring complaints are not referenced within health records in adult mental health.

The Trust currently has 6 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).

Mental Health Act

14 complainants raised concerns with the Trust in 2016/17 regarding detention under the Mental Health Act, 5 of these were raised by relatives.

Of the 9 service users who complained, 6 described themselves as white British, 1 as mixed race and 2 chose not to specify their ethnicity.

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

CQC/ ICO

During 2016/17 the Trust received 14 requests for information from the **CQC** – 6 relating to forensic services, 4 to acute mental health services, 3 to community services and 1 to older people's services. All issues were subject to investigation and responses provided to the CQC. All cases are closed.

The **Information Commissioner** is currently reviewing the Trust's response to two separate FOI requests made in April 2016 in relation to the provision of Art Therapy in Calderdale.

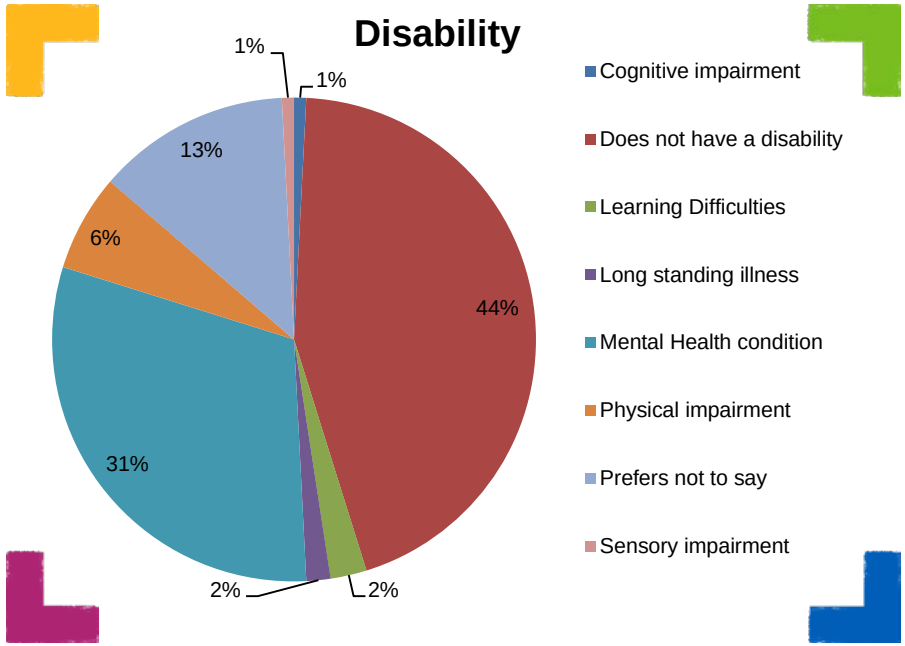
Equality Data

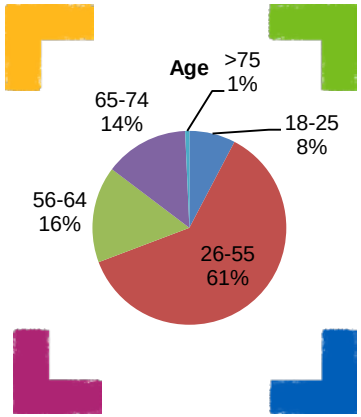
Equality data is an indicator of who accesses the complaints process. It is about the person raising the issue, who is not necessarily the person receiving services. Data is captured, where possible, at the time a formal complaint is made, or as soon as telephone contact is made following receipt of any written concerns. Information is shared with the complainant explaining why collection of this data is important to the Trust to measure equality of access to the complaints process. We offer assurance that providing data has no impact on care and treatment or on the progression of a complaint.

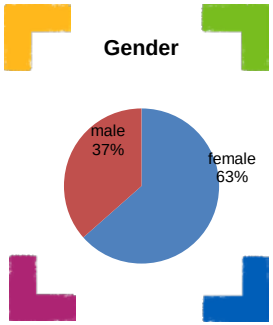
178 complaints were closed. Complaints were raised by service users (78), carers/ and or family members (79) and third party's including MPs (21). Equality data was collected for 114 contacts. 43 complainants declined to provide equality data and data is not collected about 3rd party agents.

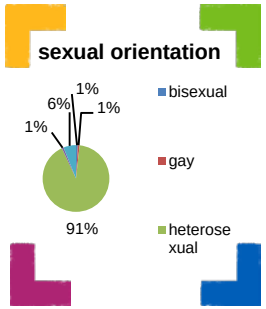
The Team continues to explore best practice in equality data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

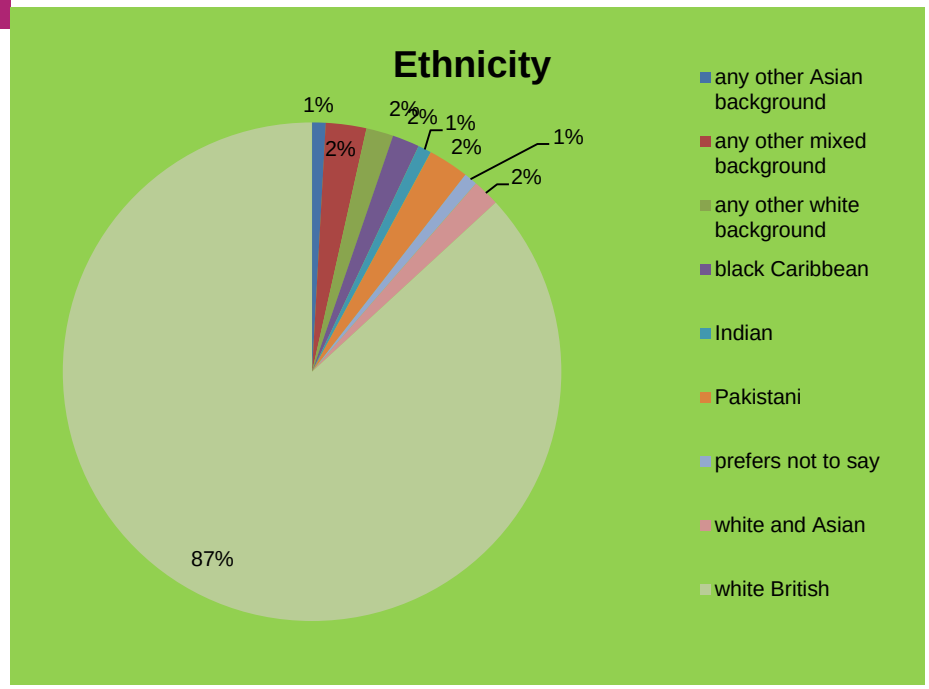
The charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. Equality data is collated Trust wide.





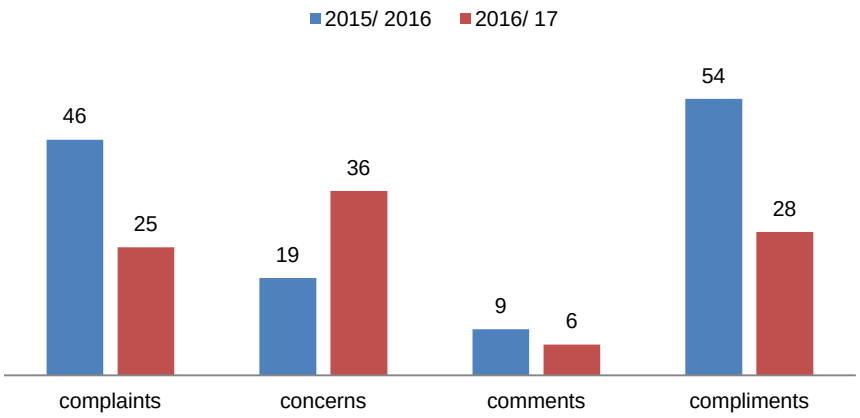




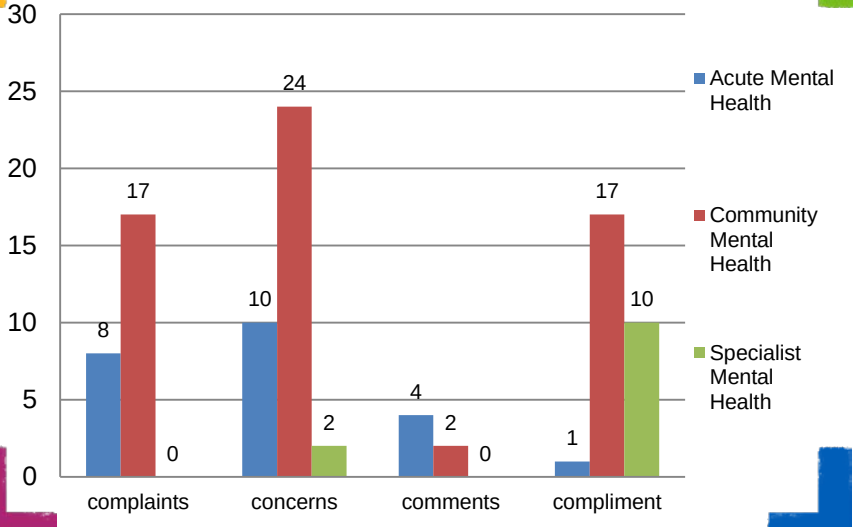


Barnsley Business Delivery Unit
Mental Health Services

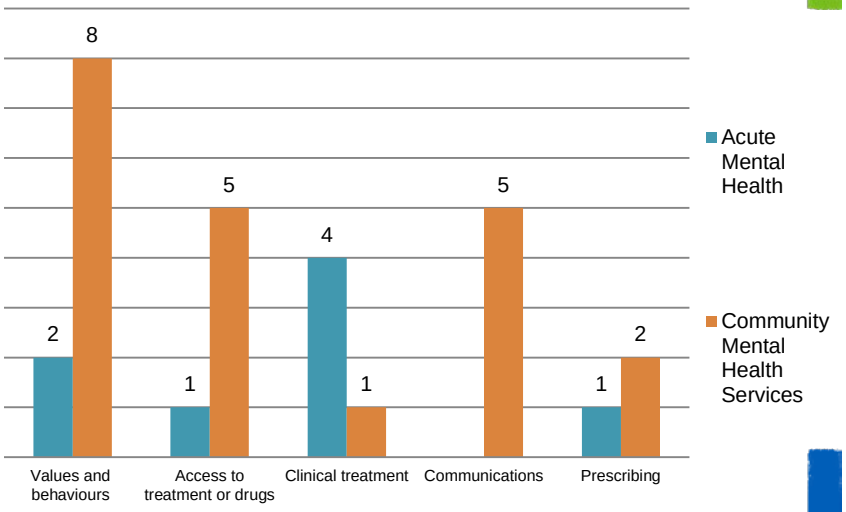
number of issues



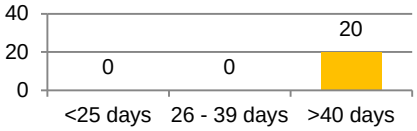
issues



Top 5 themes of formal complaints

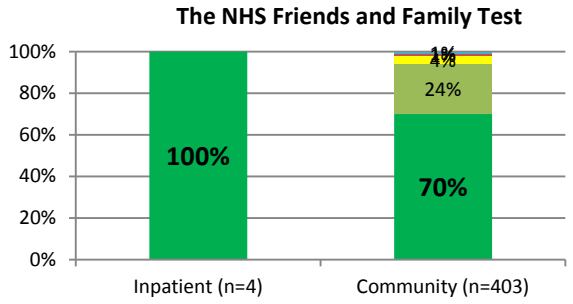


response rate



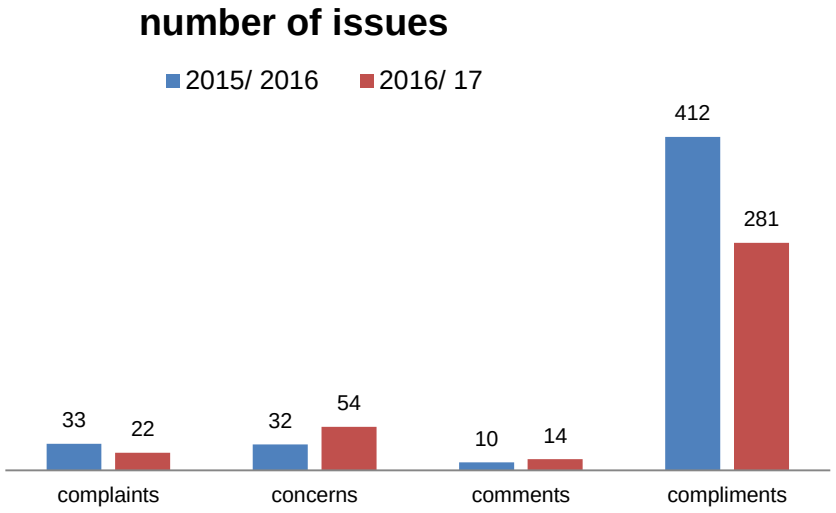
Scrutiny of issues and responses has added to delays in responding to complainants. Fortnightly reporting to BDUs, which is shared with district directors, deputies and 'Trios', identifies areas of concerns which require action and identify any lessons learned to inform governance processes.

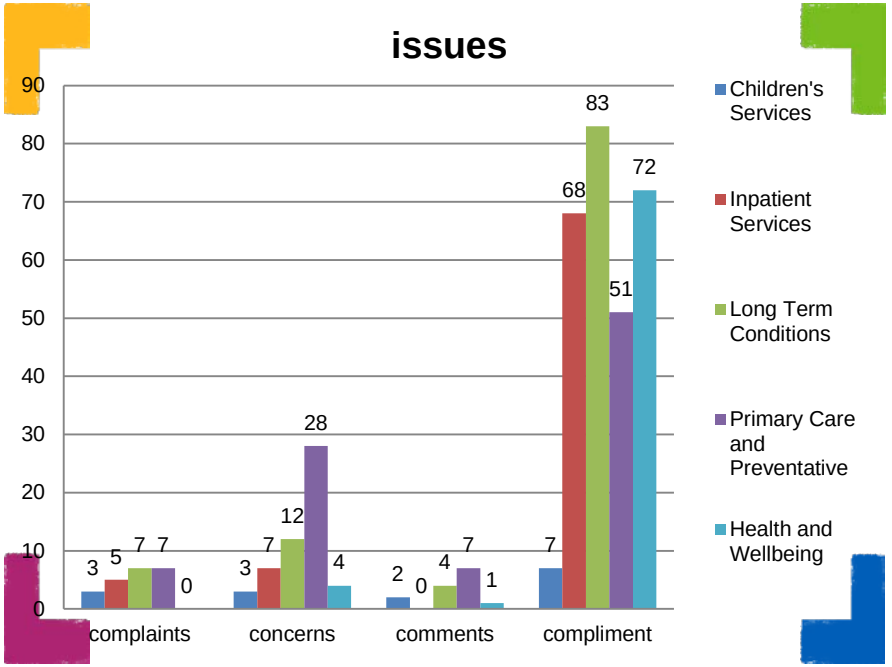
The NHS Friends and Family Test

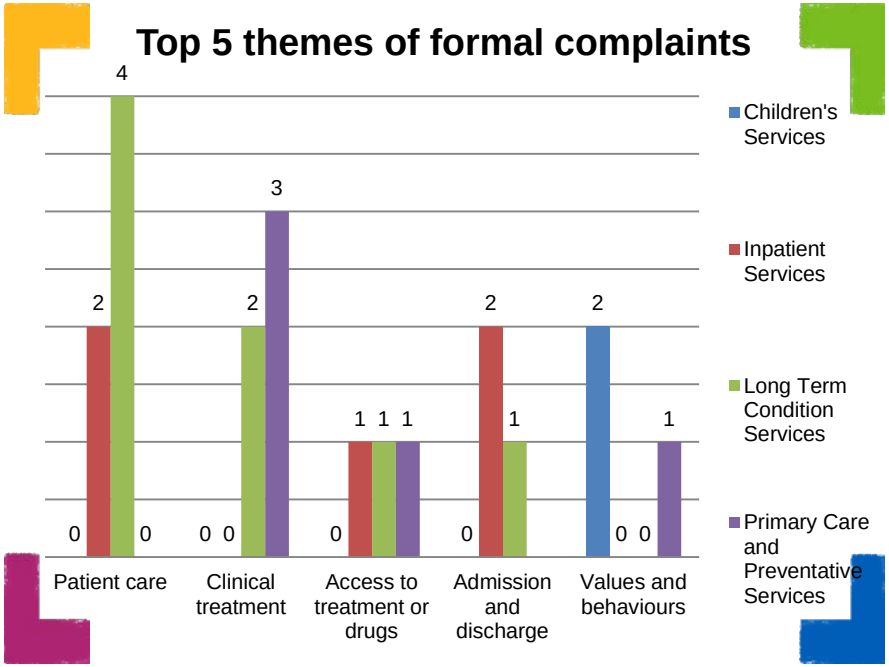


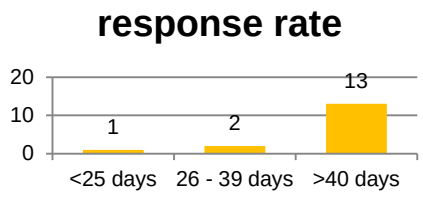
100% of inpatients and 94% of community service users would recommend services

Barnsley Business Delivery Unit
General Community Services









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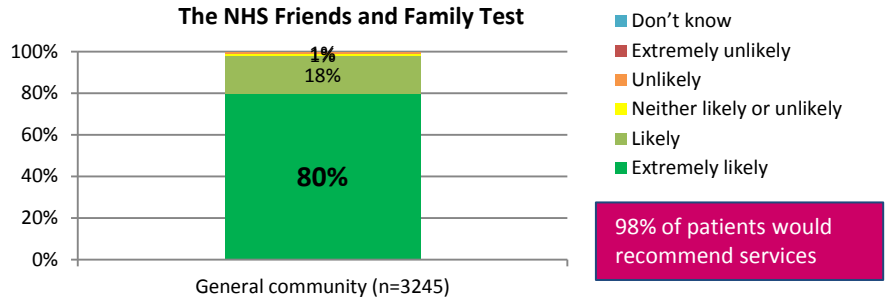


98% of patients would recommend services

Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

Barnsley - Mental Health Services

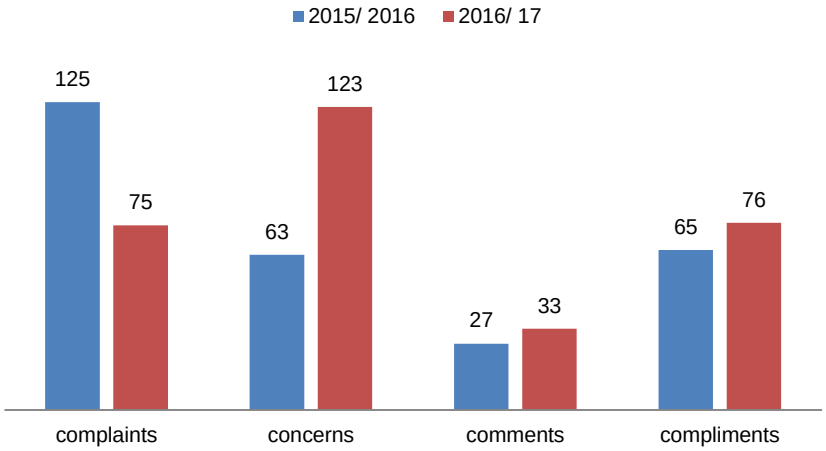
- The importance of checking understanding of information provided to carers/relatives has been reiterated to staff through supervision – *CMHT OPS*
- Staff will ensure service users have sufficient information about the support available following assessment - *CMHT North*
- Staff have been reminded to provide the general switchboard number so that calls can be answered and redirected to help service users contact the appropriate clinician or team – *CMHT North*
- Staff to ensure service users and carers are appropriately signposted to additional sources of support where indicated - *CMHT Dearne*
- Staff have been reminded of the importance of passing on messages and returning telephone calls in a timely manner. This will be monitored by the team manager - *Dearne CMHT*
- Improved information will be made available to service users on the ward regarding the use of seclusion and the circumstances when this might be necessary - *Clark Ward.*
- Staff to ensure discussion with services users (and appropriate family members) following any period of seclusion. This will be monitored through monthly team meetings. Staff will ensure appropriate documentation is completed following any restraint, monitored through clinical supervision and subject to regular audit - *PICU Inpatient Services – Melton Ward.*
- Service manager to review discharge medication system, medication policy and the process for communicating changes to medication - *Willow Ward.*
- The importance of clear communication with carers/relatives has been reiterated during team briefs and staff supervisions - *Willow Ward.*
- Improved information will be provided regarding the process for initial appointments. Additional signage will also be erected at premises used by Trust - *IAPTS*
- The importance of ensuring instructions from legislation are clearly communicated with service users will be reiterated to staff - *CMHT OPS*
- Training to be provided on confidentiality when accessing records - *Recovery College.*

Barnsley - General Community Services

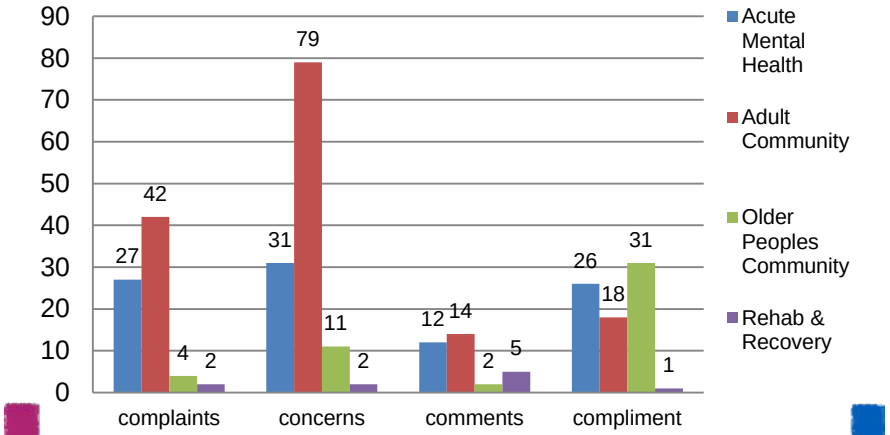
- Staff have been reminded of the importance of providing education and advice to relatives who support care, in order to ensure appropriate techniques are utilised – *Long Term Conditions (District Nursing)*
- Staff have been reminded through routine meetings and supervision of the importance of introducing themselves professionally and explaining their role to new clients - *Physiotherapy/Musculoskeletal, Mount Vernon*
- Staff have been reminded of the importance of ensuring that any communication provided is clear and to ensure patients feel confident in asking for assistance - *Joint Therapy Services*

Calderdale & Kirklees Business Delivery Unit

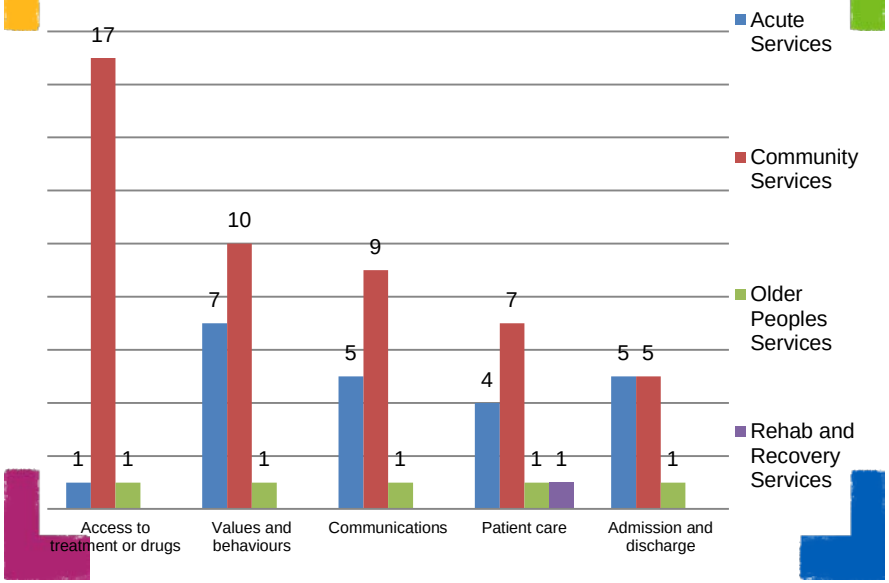
number of issues



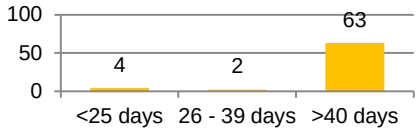
issues



Top 5 themes of formal complaints



response rate



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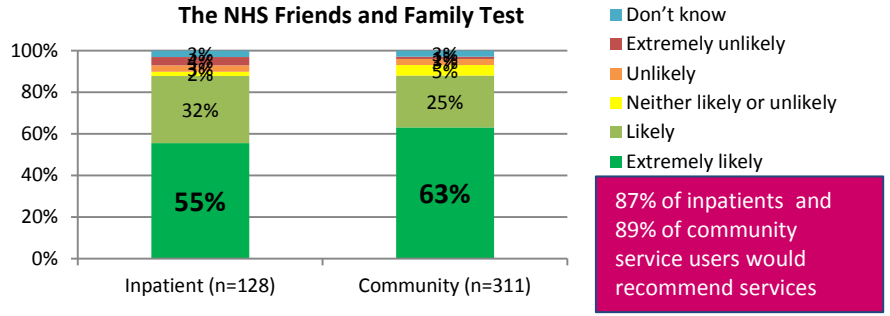


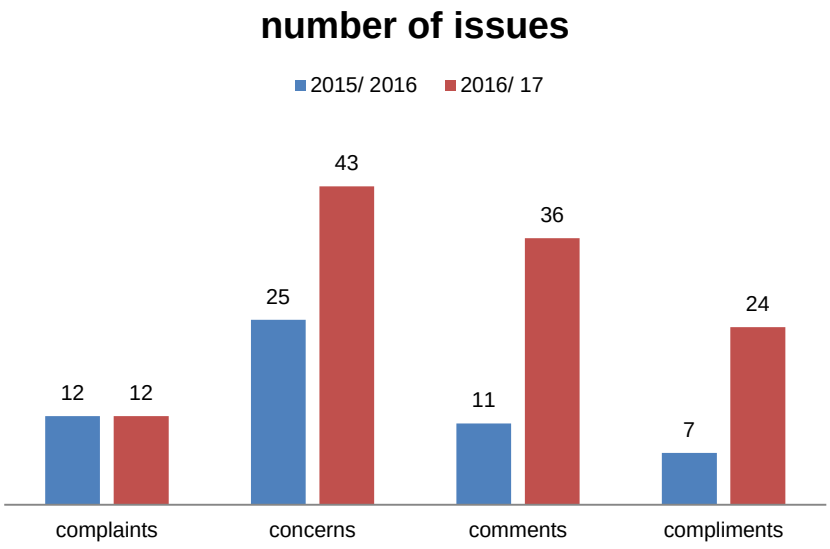
87% of inpatients and 89% of community service users would recommend services

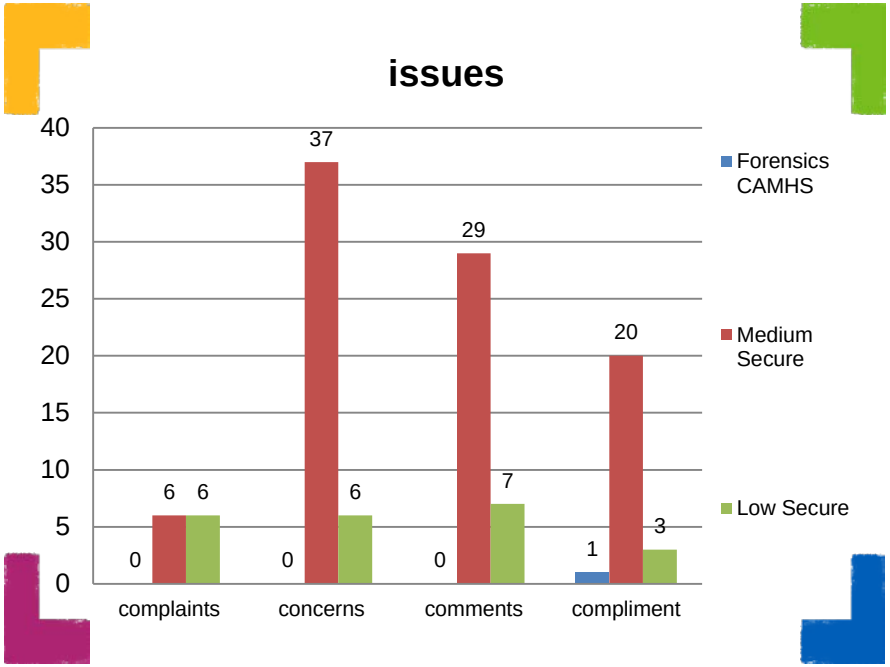
Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

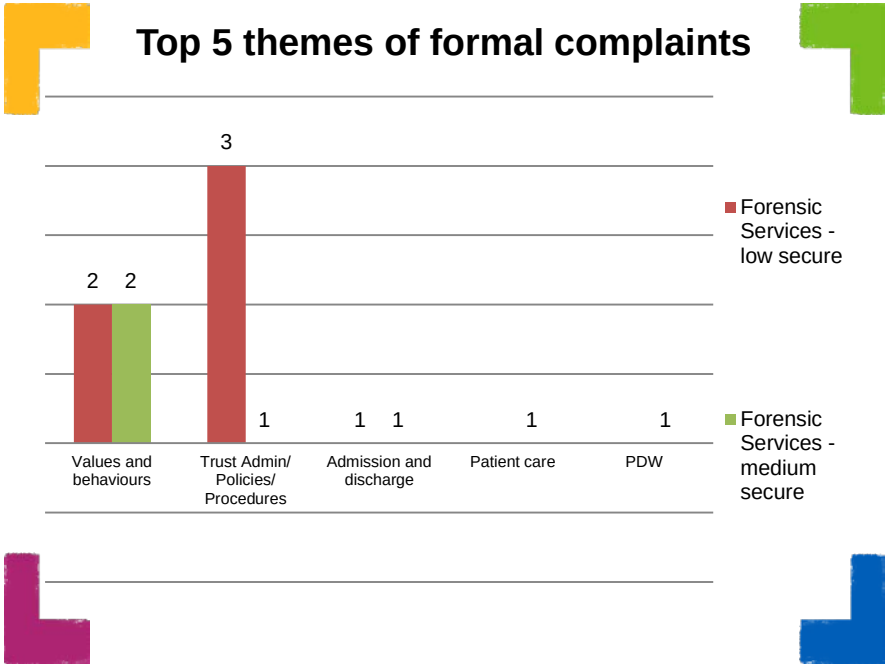
Calderdale & Kirklees Business Delivery Unit

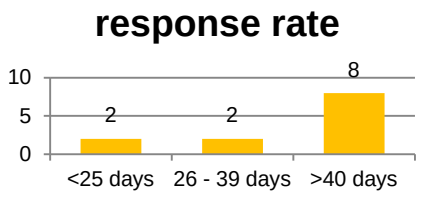
- Staff have been reminded of the importance of clear communication regarding the service offer, support available, and keeping families up to date where appropriate, including timely and accurate record keeping. - *Intensive Home Based Treatment Team (Kirklees)*
- Staff to ensure they clearly explain rights under the Mental Health Act. Staff to also ensure telephone calls are logged and that calls are returned in a timely manner - *Ward 18, Priestley Unit*
- Staff to ensure they check understanding when explanations about care decisions are offered. - *CMHT - Community Therapies Team (South Kirklees)*
- Policies on the management of money and property have been reviewed and appropriate guidance put in place. - *CMHT - Care Management Team (North Kirklees)*
- A new process has been implemented to ensure that when an individual is first offered an appointment with IAPT they are provided with a copy of the Trust's "Confidentiality of your information" leaflet which explains why we collect information, what this might be used for, how we keep people's information safe and any circumstances which might mean we need to share it*. Psychology Services - Kirklees (Adult)*
- Information to be acted on at the earliest opportunity*. Memory Service (OPS)*
- Staff to ensure clear information regarding care and treatment decisions is shared sensitively and without delay. To be monitored through clinical supervision. *CMHT Lower Valley Calderdale*
- All to ensure the leaflet explaining the Mental Health Act is available to service users and carers. *Acute Services – Ward 18*
- Staff to ensure conversations with carers, including explanations regarding clinical decisions, are fully recorded. *Older peoples Services – Inpatient – Ward 19*
- Staff to ensure written information (leaflet) is available when undertaking Mental Health Act assessment in general hospital setting. *CMHT - Care Management Team (N Kirk)*
- Staff to ensure they involve families and carers in discharge planning and that there is clear communication between teams regarding sharing pertinent information - *Intensive Home Based Treatment Team / Crisis Team*
- Trust bank is being used to fill gaps in team capacity pending recruitment to vacancies. - *Lower Valley CMHT*
- Information Governance informed of confidentiality breach. Team to ensure that contact information is recorded accurately - *Lower Valley CMHT*
- Existing referral systems have been reviewed and changed to minimise delays in accessing treatment - *Care Management Team*
- New telephone line has been installed to improve ease of contact with the services. - *Improving Access to Psychological Therapies*
- Staff to ensure that all service property is recorded as received - *Ashdale Ward.*
- Apology provided for lack of consistency regarding consultants. Meeting offered to discuss care and treatment. *CMHT Calder Valley Calderdale*
- Assurances provided that engagement events are currently under way to review services in Calderdale. *Psychological Therapy Services*
- Feedback provided to the domestic team regarding cleanliness. Acute Services *(136 suite)*
- Letters updated with correct contact details, and answer machines now contain up to date information for the service. *CMHT Lower Valley Calderdale*
- Staff reminded of the importance of passing on messages promptly. Also factors surrounding the complaint will be discussed with the staff member in appraisal to support learning and reflection. *CMHT Lower Valley Calderdale*
- Staff reminded to send out contact letter to individuals in circumstances where there is no response to telephone messages, to ensure appropriate contact. *Care Management Team*
- Changes to medical staffing will support consistency of care and treatment for service users *Care Management Team.*

Forensic Business Delivery Unit









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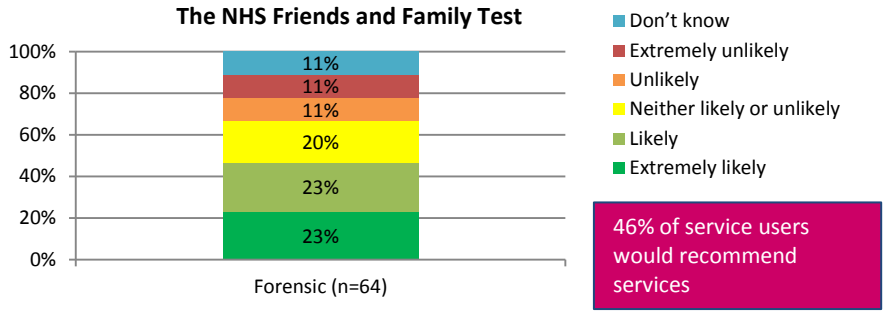


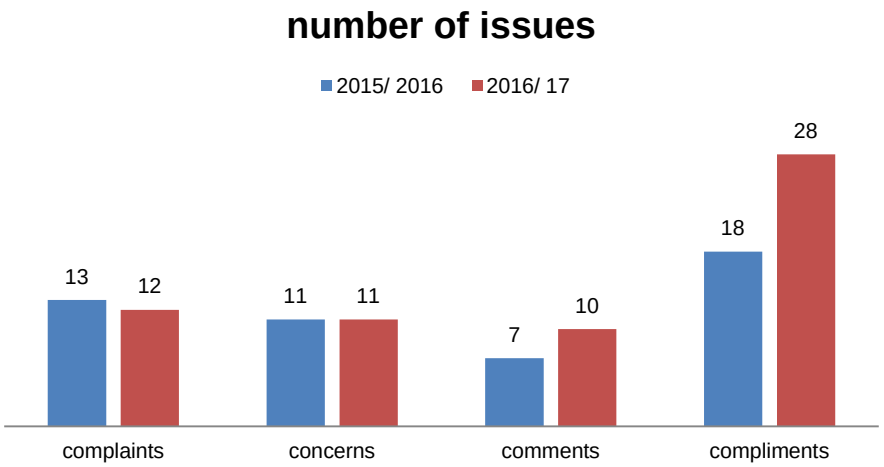
46% of service users would recommend services

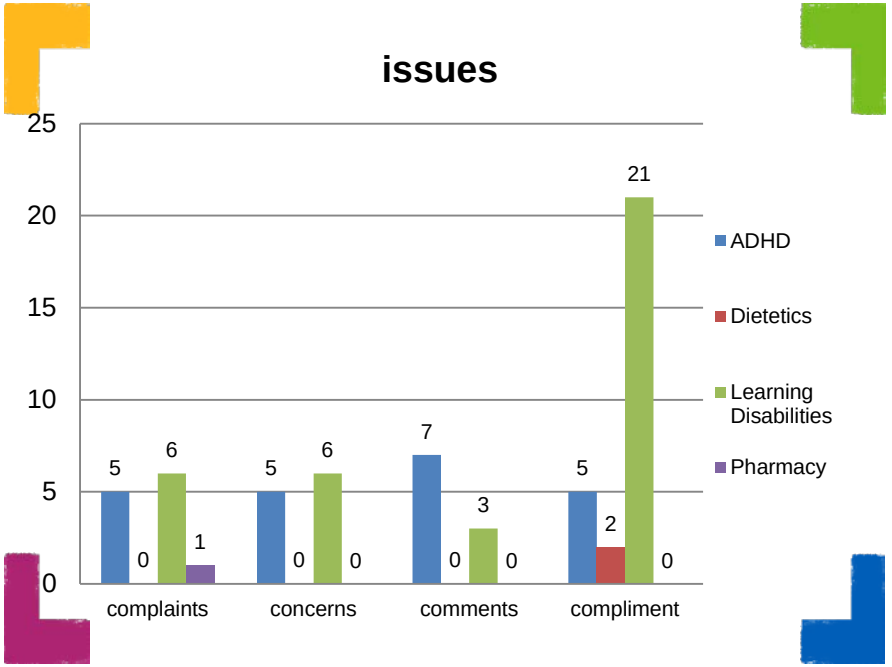
Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

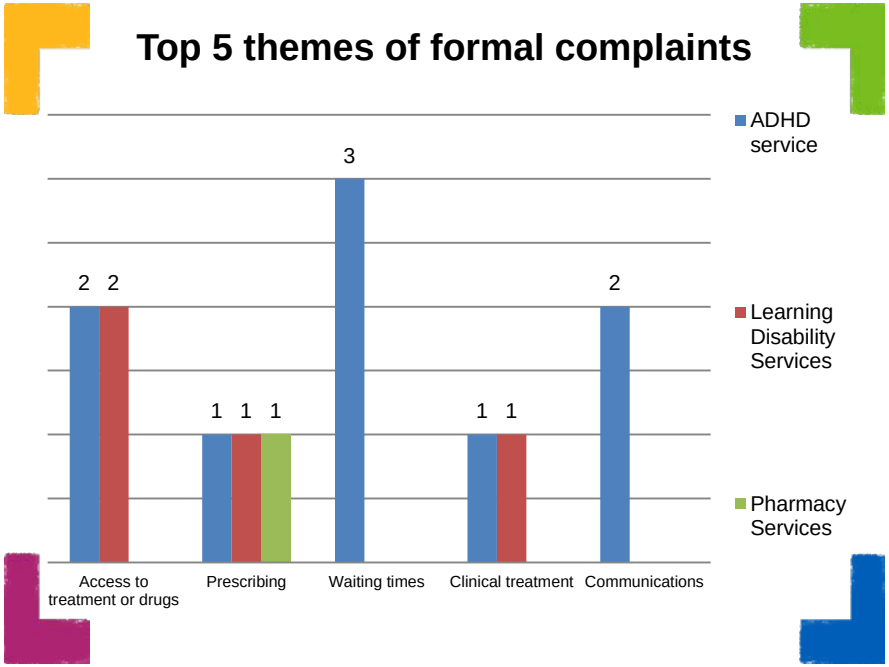
Forensic Business Delivery Unit

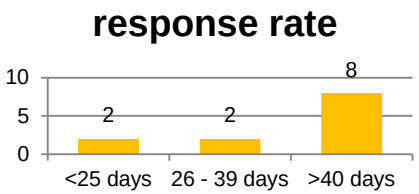
- Regular 1:1 meetings have been introduced with service users to encourage dialogue and feedback. This has led to an increase in concerns but helps to offer a response in real time. - *Waterton Ward Forensic Rehabilitation, Newton Lodge*
- All staff are mindful of the importance of good communication. A review of process for planning section 117 meetings prior to transfer has been undertaken and changes have been implemented. - *Thornhill Ward (The Bretton Centre)*
- Team to ensure appropriate response to changes in service user presentation to ensure the right staff support is offered (for example staff working in pairs) - *PICU/Acute inpatient units - Bronte, Hepworth ward.*
- Improved explanation / information will be offered regarding decisions about or changes to Section 17 leave arrangements - *Thornhill Ward.*
- There is currently a rolling programme of recruitment ongoing to address staffing levels - *Appleton Ward*

Specialist Services Business Delivery Unit excluding CAMHS









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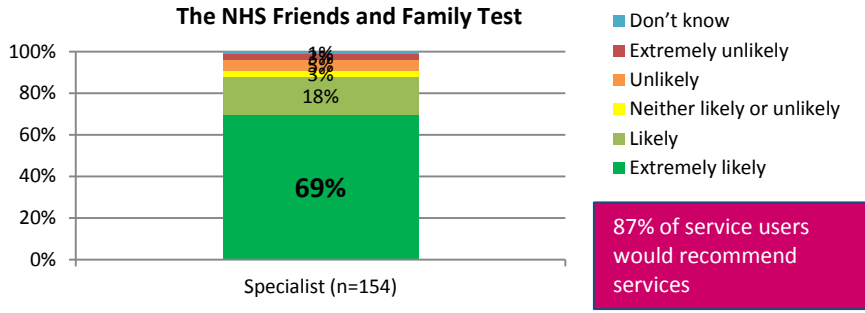


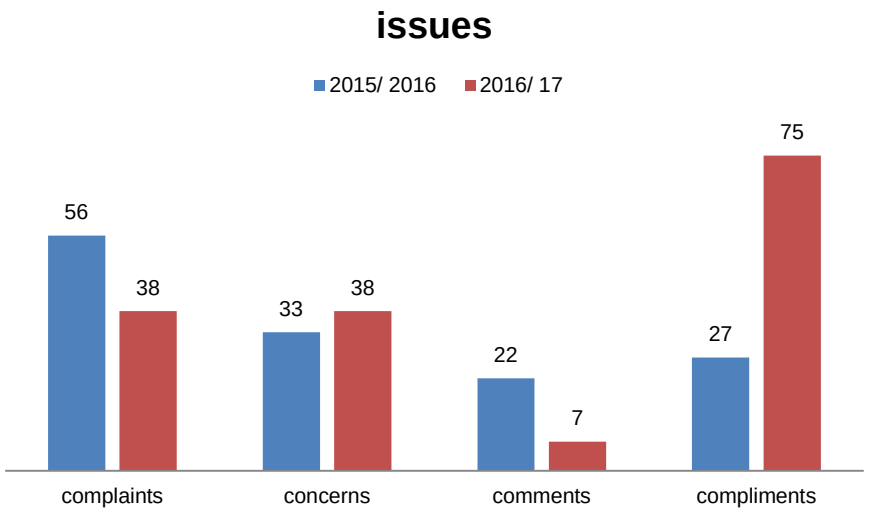
87% of service users would recommend services

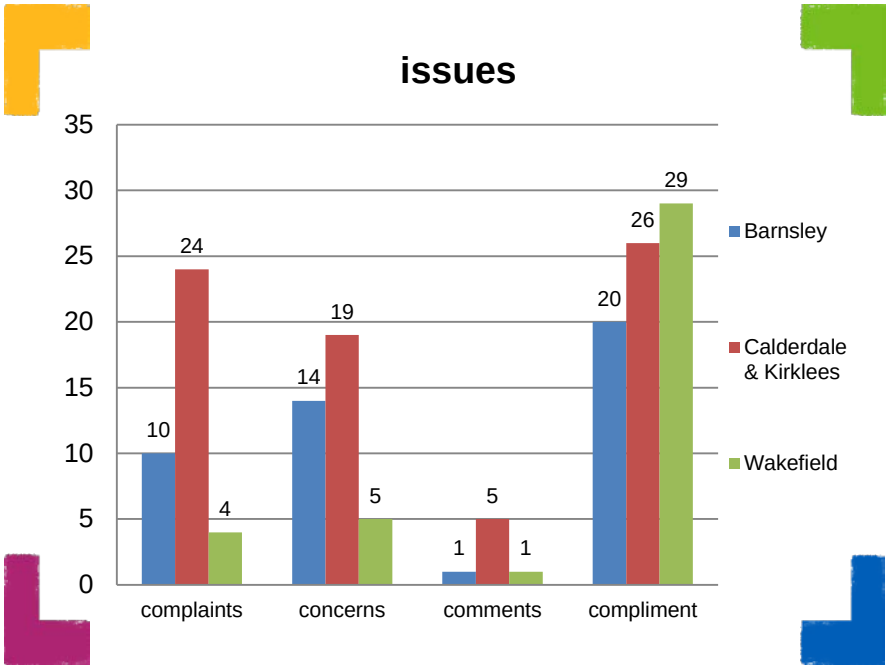
Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

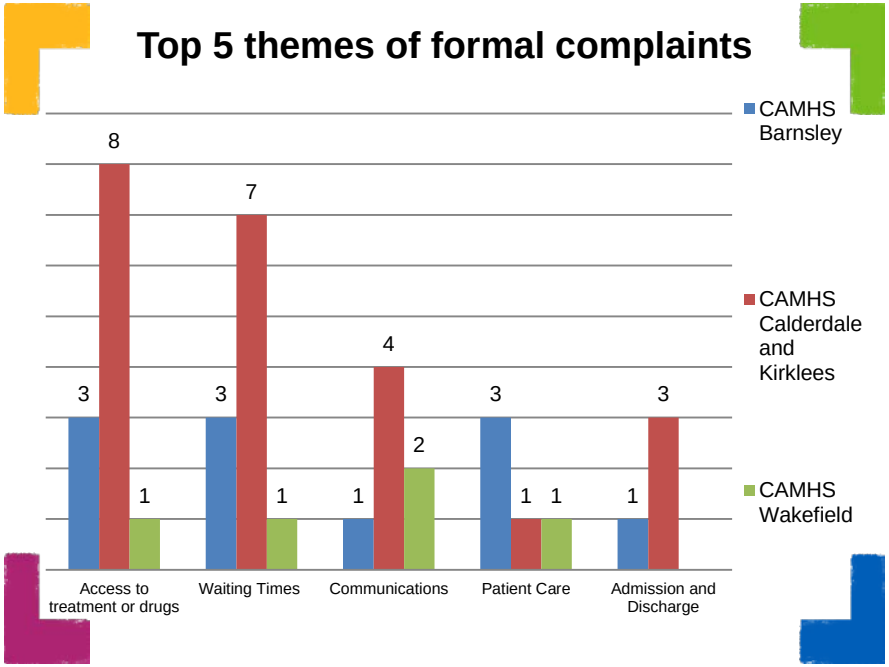
Specialist Services Business Delivery Unit excluding CAMHS

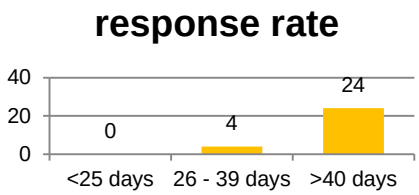
- Staff to check understanding regarding the purpose of appointments and how information gathered at appointments is used to inform the assessment process. Where copies of assessment documentation is requested – this should be provided in a timely manner. - *Children's Learning Disability Team – Kirklees*
- The service is reviewing the current process for the receipt and review of test results including CT scans. This will ensure that results requested by professionals are reviewed prior to them being filed in health care records and that a note is placed on file to confirm the actions taken - *Barnsley Community Learning Disability Team*
- Team to check service user understanding of discharge arrangements and signposting to additional sources of support - *ADHD Service*
- Review underway of caseload management to ensure delays are minimised - *Children's Learning Disability Team, Calderdale.*
- Confirmation of transport bookings will be provided to service users/carers in the future. The service will look into the best way to do this by asking people who use the service what would be most helpful. This might include for example a text messaging service prior to appointments - *Community Learning Disability Team (PLD)*
- Review of the screening tool used - *ADHD services*
- Future home visits to be carried out by 2 members of staff - to ensure that staff receive an increased level of supervision. All future communication to be backed in writing - *Community Learning Disability Team (PLD)*
- The service is identifying additional support regarding creative approaches used in recovery - *Community Learning Disability Team (PLD)*
- The service will ensure that staff establish preferred communication methods to help people receive the information they need in a suitable format - *Community Learning Disability Team (PLD).*

Child and Adolescent Mental Health Services









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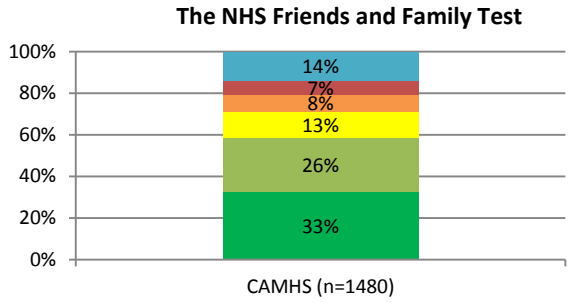


59% of service users would recommend services

Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

Child and Adolescent Mental Health Services - Barnsley

- Staff to ensure that if appointments need to be cancelled at short notice for any reason that action is taken to ensure an alternative appointment is offered asap.
- Team to ensure appropriate support and advice is in place during the wait time for an appointment.
- Staff to ensure clear information is provided regarding the separate waiting lists that operate.
- The team manager to review the process for telephone contact with the service, relay of messages to clinicians and response times.
- Team has noted the need to better explain discharge from the service and referrals to tier 2 services.
- Service to provide additional information regarding referrals to other services and discharge from CAMHS.
- The service is currently reviewing how appointments are managed to reduce delays as far as possible.
- The team is working to improve telephone message response times.
- General Manager is reviewing how messages are recorded and conveyed to ensure communication is of a high standard.
- The service is reviewing the process for cancellation of appointments to ensure consistency of approach.

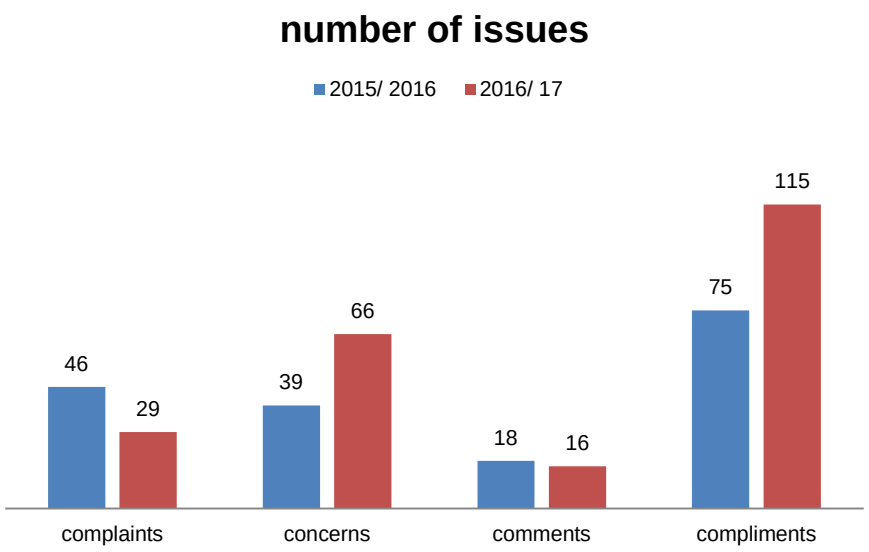
Child and Adolescent Mental Health Services – Calderdale & Kirklees

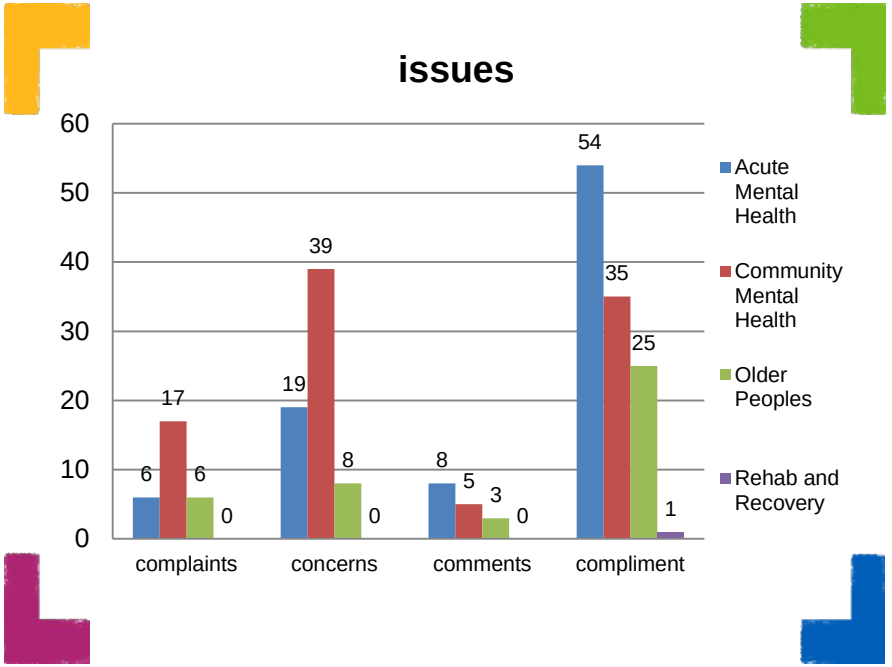
- Service to always check service users/carer's understanding of any information provided.
- Staff reminded through regular supervision of the importance of providing clear information to service user, carers and families regarding decisions affecting care, and that this is documented
- Staff to ensure all parties present before commencing any review.
- Staff to ensure all discussion regarding the rationale for clinical decisions is fully documented to support improved communication.
- Service will ensure that expectations of service users/carers are discussed at the beginning of each session.
- CAMHS/ASD team will ensure that information is provided regarding possible wait times.
- Service to provide additional information to referrers and to families regarding the criteria for access to services and about discharge from the service.

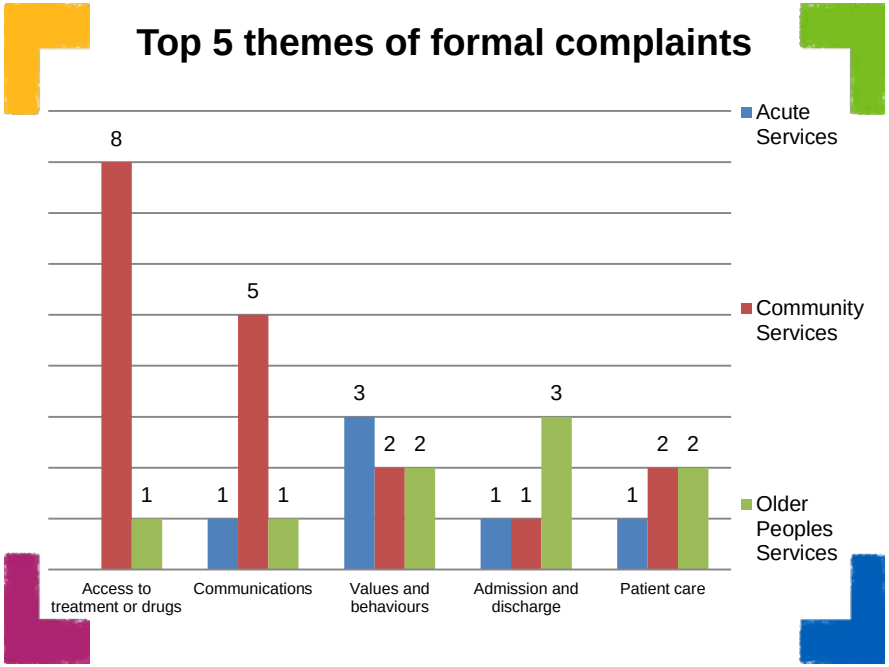
Child and Adolescent Mental Health Services – Wakefield

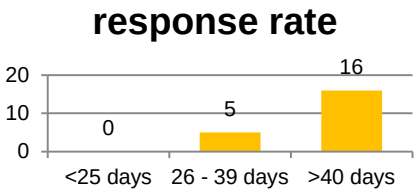
- Staff have been reminded of the importance of ensuring clear and accurate communication with families regarding appointments. There is also a focus on ensuing telephone calls are returned in a timely manner

Wakefield Business Delivery Unit









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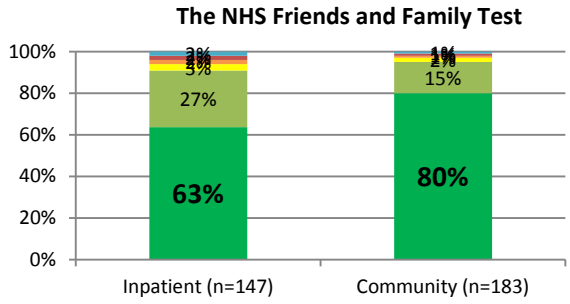


90% of inpatients and 95% of community service users would recommend services

Action taken in response to feedback (delivery of actions monitored through BDU governance processes):

Wakefield Business Delivery Unit

- Staff to ensure decisions made are confirmed in writing to service users and professionals involved - *CMHT 3 - Horbury, Wakefield South (WAA)*
- Staff to check out understanding of information shared with service users and families and to ensure decisions and actions are fully documented.
- Assurance to be provided to service users regarding how information regarding their psychiatric and forensic history is to be used by health professionals - *Assertive Outreach Team (West) -Horbury, Wakefield*
- Staff will ensure they check understanding of explanations provided to service users regarding decisions or changes to S.17 leave - *Trinity 1*
- Following feedback that decisions are not properly understood – staff will check out understanding about care and treatment as a matter of routine - *Assertive Outreach Team/ Chantry Unit.*
- Staff to discuss with carers and services users sources of additional support that might be available on discharge - *Trinity 1*

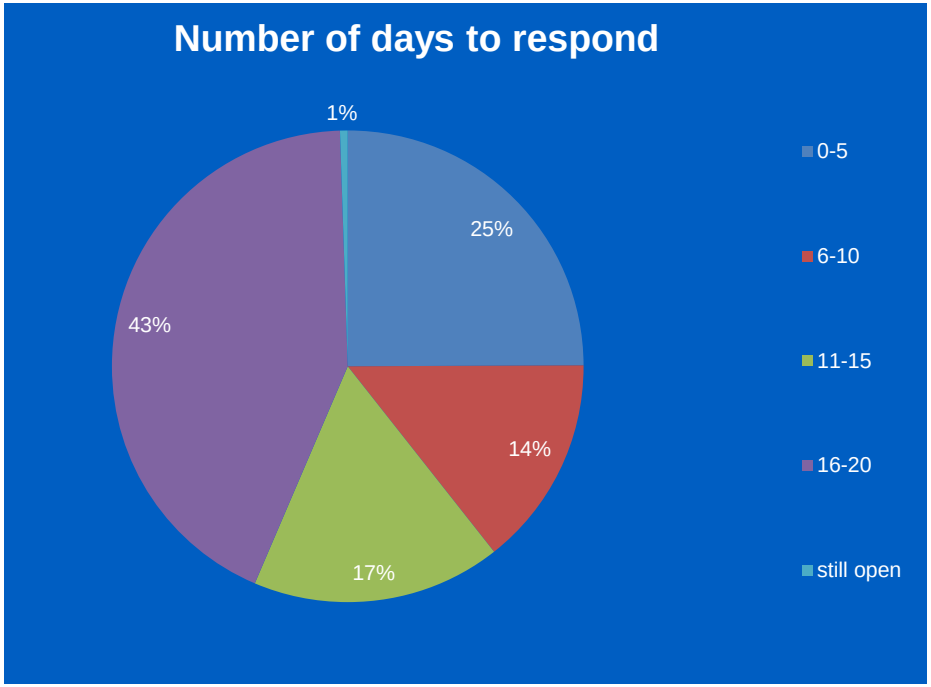
Freedom of Information requests

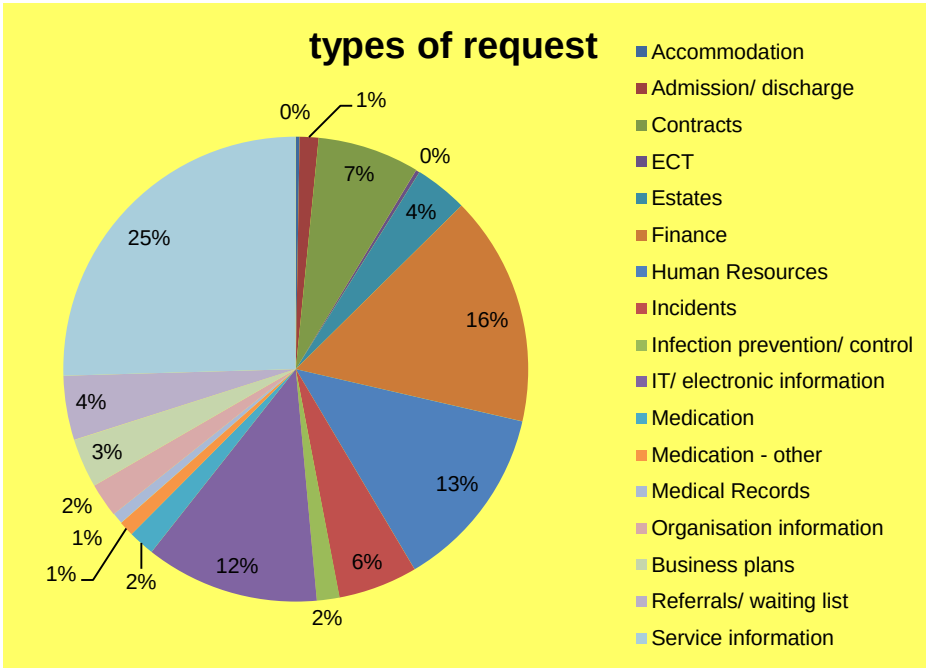
381 requests to access information under the Freedom of Information Act were processed in 2016/ 17, an increase on the previous year when 265 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

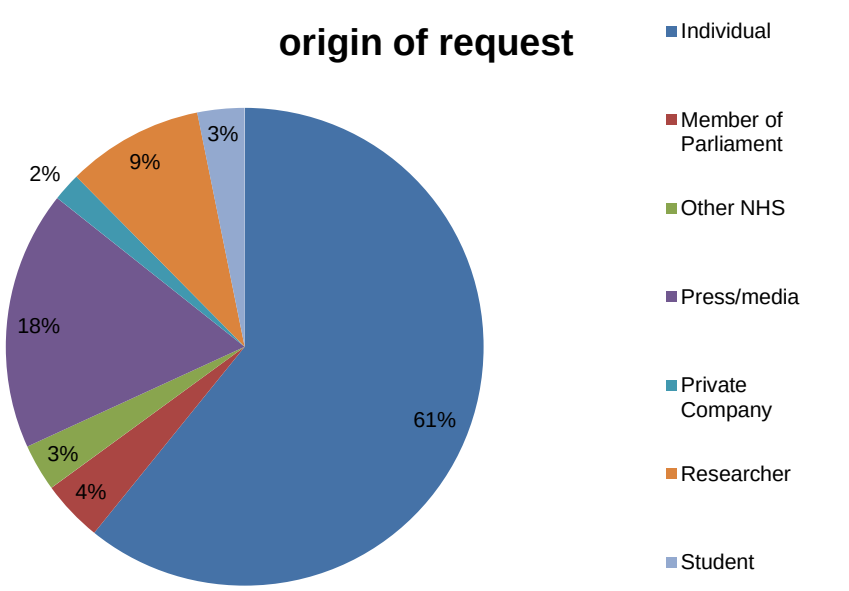
During the year, 25 exemptions were applied –

- 2 x Information reasonably accessible to the applicant by other means (section 21)
- 1 x Information intended for future publication and research information (sections 22 and 22A)
- 3 x Law enforcement (in relation to IT cyber security) (section 31)
- 2 x Prejudice to the effective conduct of public affairs (section 36)
- 5 x Personal information (section 40 and regulation 13)
- 4 x Information provided in confidence (section 41)
- 8 x Information prejudicial to commercial interests of a third-party (section 43)

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.

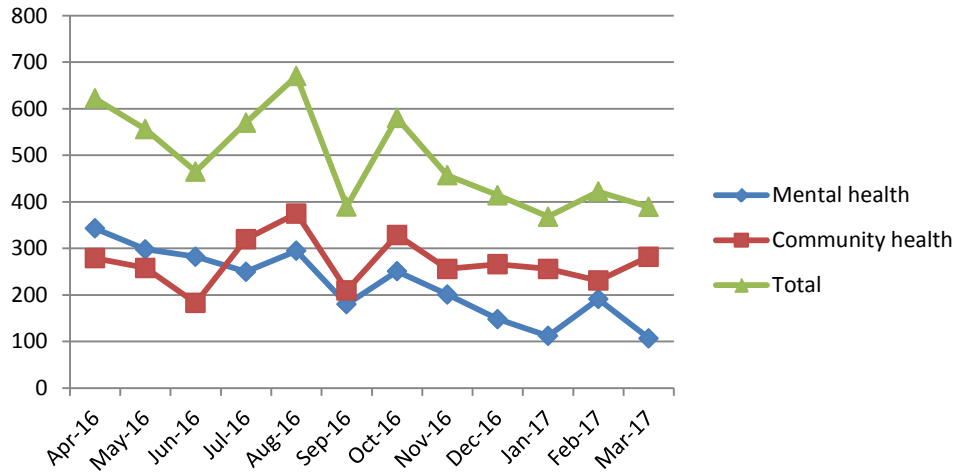


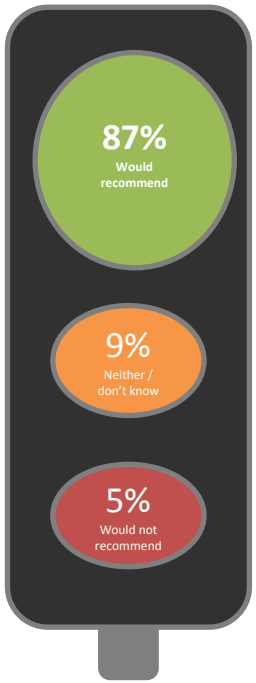




The NHS Friends and Family Test 16/17

In 2016/17 the Trust received 5903 responses, an average of 492 responses per month (mean – mental health and community).





Top responding teams

1. Community physiotherapy
2. Children's Speech and Language therapy
3. Podiatry

Comment Themes

Top positive theme:
Staff

Top negative theme:
Communication

Example 'you said, we did' poster:

NHS
South West Yorkshire Partnership
NHS Foundation Trust

You Said, We Did

Trinity 2
March 2017

"Toilets still blocking"

Reported the toilets to Facilities and asked them to urgently review

"More fruit for breakfast"

We have asked the housekeepers to order more fruit for the ward

"Please can we have serviettes with meals?"

We are looking at sourcing serviettes

"Please can we have copies of the bible on the ward?"

We will speak to the chaplain about this and get back to you

If you require any further information please contact:

Donna
Ward Manager

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 7.1

Title:	**Annual Report and accounts and Quality Account 2016/17**
Paper prepared by:	Director of Finance
Purpose:	To confirm the submission of the 2016/17 annual accounts, annual report and quality account. To explain the process undertaken to generate these submissions and provide assurance regarding the governance of the process To provide the Board with the reports generated by Deloitte LLP following their annual audit
Mission/values:	The annual report, accounts and quality report form part of the Trust's governance arrangements, which support the Trust's mission and values. The annual report provides a summary of the Trust's performance, the accounts demonstrate financial probity and the quality report outlines the Trust's approach to quality, improvement in services and achievement of its quality priorities.
Any background papers/ previously considered by:	➢ The draft annual governance statement was reviewed by the Trust Board on 25 April. The final draft was included in the annual report reviewed by the Trust Board on May 23rd ➢ The draft annual report had input from executive directors and other senior managers and stakeholders, and was shared with all Board members for comment and feedback. The final draft was reviewed by the Board on May 23rd. ➢ The draft quality report was considered by the Member's Council Quality Group on 9 May 2017 and by the Clinical Governance and Clinical Safety Committee on 22 May 2017. The final draft was reviewed by the Trust Board on May 23rd. ➢ The annual accounts were reviewed by the Non-Executive Directors on May 2nd and at Trust Board on May 23rd. Accountants on the Board also reviewed and raised questions and comments which were responded to. ➢ The final version of each was reviewed by the Audit Committee on 25th May 2017
Executive summary:	➢ All documents were submitted to NHS Improvement ahead of submission deadlines. ➢ Each document was subject to significant Board scrutiny and oversight ➢ With regard to the account Deloitte issued an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement ➢ With regard to the Quality account the Trust was issued with the Limited Assurance report, that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data ➢ Copies of both audit reports (accounts and quality account) are

	attached to this paper.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the update and make any further COMMENTS on the process relating the annual report, accounts and quality account process and submissions.** ➢ **RECEIVE the external audit reports relating to the annual accounts and quality account and comment accordingly.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

2016/17 Annual Report, Annual Accounts and Quality Account

Introduction

In line with statutory requirements the Trust has submitted an annual report, its annual accounts and quality account to NHS Improvement. Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which is due to occur in July. This document explains the process undertaken and provides the external audit reports.

Annual Governance Statement

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHS Improvement based on Treasury requirements. The draft AGS was approved by the Trust Board on the 25th April 2017, subject to review by the external auditors. The AGS contained the Head of Internal Audit overall opinion of significant assurance with minor improvement opportunities.

Annual Accounts

The annual accounts were produced in line with accounting standards (FRS) and followed guidance and instruction provided by NHS Improvement. The draft accounts were shared with accountants on the Trust Board for comment and feedback, and subsequently discussed with all non-executive directors on May 2nd. Responses were provided for all questions and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Extended Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Trust Board on May 25th. They were approved at that Trust Board subject to any final review amendments. There were no notable additional amendments following the Trust Board and final review and signature took place at the Audit Committee on May 27th. A log was kept of all adjustments made from version to version. The accounts were then submitted to NHS Improvement

Annual Report

The production of the annual report was co-ordinated by the Integrated Governance Manager and included contributions from appropriate executive directors and other senior managers. The annual report was shared with non-executive directors and the lead governor for comments. As with the annual accounts the report was reviewed and approved subject to final amendments at the Trust Board on May 25th. Final review and signature again took place at the Audit Committee on May 27th. The report was then submitted to NHS Improvement.

Quality Account

The Quality Account 2016/17was produced in line with the requirements of both the Department of Health, ***'Quality Account Toolkit (2010)***' and NHSI, '***Detailed requirements for quality reports'*** (2017).

The production of the quality account report is a year -long process. Quality priorities were agreed by EMT (2016), allocated a lead individual and monitored in relevant working groups throughout the year, for example, the Patient Safety Group. A bi -monthly progress report was submitted to Clinical Governance & Clinical Safety Committee, Member's Council Quality sub- group on a quarterly basis and Clinical Commissioning Groups Quality Boards, as requested.

The Quality Improvement and Assurance Team facilitate the production of the quality account report with input from BDU representatives and quality academy support teams such as finance, performance and information, information governance, human resources and contracting. A requirement of the quality account process is that our External Auditors (Deloitte) are required to undertake an audit of two mandated data items, in line with NHSI requirements set out in '***Detailed guidance for external assurance on quality reports 2016/17'.*** Following the audit the Trust were issued with the Limited Assurance report, that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data. A copy of the External Assurance report is attached.

A draft quality account report was produced that was commented upon by EMT, Member's Council Quality sub-group and Clinical Governance & Clinical Safety Committee before sign off by Audit Committee as part of the Annual Report. The report was submitted to NHSI in May 2017.

External Audit Report

Deloitte LLP are the Trust's external auditors. Following completion of their audit they have produced an audit report (ISA 260). A copy of the ISA 260 is attached to this report. Key points to note from the report are:

- No significant audit adjustments or disclosure deficiencies were identified
- An unmodified audit opinion was issued with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- We have not identified any inconsistencies between the financial statements and the FTCs.
- With regard to areas of risk identified Trust management judgements were consistent with Deloitte's expectations
- Four recommendations made relating to asset valuation process, third party assurance for IT systems and finance risk register. Management responses and progress will be reviewed at the Audit Committee.

Conclusion and Recommendation

In conclusion the Trust met all its submission deadlines associated with its statutory returns covering the annual accounts, annual report and quality account. Input and feedback was regularly sought from all Board members and a range of other key stakeholders. External Audit provided an unmodified opinion in relation to the accounts.

Trust Board is asked to note the submission of the statutory returns, process undertaken to generate the accounts and reports and the assurance provided by our external auditors.

Deloitte.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Report to the Audit Committee on the 2016/17 audit

May 2017

Contents

Our final report

Appendices

Director introduction

The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have 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.

I have pleasure in presenting our final report to the Audit Committee for the 2017 audit.
I would like to draw your attention to the key messages within this paper:

Status of the audit	Our audit is substantially complete subject to completion of the following principal matters: • Completion of internal quality assurance procedures; • Our review of events since 31 March 2017; and • Receipt of signed management representation letter. Our Independent Examination of South West Yorkshire Partnership Foundation Trust and Other Related Charities is underway and will finalise this work over the next month.
Conclusions from our testing	• We have not identified any significant audit adjustments or disclosure deficiencies. Unadjusted audit misstatements on page 30 would not have affected the Trust's achievement of its control total. • Based on the current status of our audit work, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement. Our audit report will include our findings on each risk, the draft of which are included next to each risk in the body of the report. • We have not identified any inconsistencies between the financial statements and the FTCs.

Director introduction
The key messages in this report (continued)

Financial sustainability and Value for Money	• The Trust reported an overall deficit for the year of £0.4m, including STF income of £2.5m; • CIP delivery was £9.0m against a £10.1m target; • The Trust has a Single Oversight Framework segmentation of 2. It is not currently subject to any regulatory action from either NHS Improvement (NHSI) or the Care Quality Commission (CQC); • Subject to appropriate disclosure in the Annual Report and Annual Governance Statement we do not anticipate reporting any matters within our audit report in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources.
Annual Report & Annual Governance Statement	• We are reviewing the Trust's Annual Report & Annual Governance Statement to consider whether it is misleading or inconsistent with other information known to us from our audit work. Based on our review to date, we consider that the Trust has followed the format prescribed by the Foundation Trust Annual Reporting Manual. We are suggesting a number of minor changes to management for consideration.
Quality Accounts	• Based on the current status of our audit work, we plan to issue an unmodified quality report opinion. The findings from our work are set out in the accompanying paper, which will be presented to the Council of Governors at their next meeting.

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.

Oversight of external audit

- At the start of each annual audit cycle, ensure that the scope of the external audit is appropriate.
- Make recommendations as to the auditor appointment and implement a policy on the engagement of the external auditor to supply non-audit services.

Integrity of reporting

- Impact assessment of key judgements and level of management challenge.
- Review of external audit findings, key judgements, level of misstatements.
- Assess the quality of the internal team, their incentives and the need for supplementary skillsets.
- Assess the completeness of disclosures, including consistency with disclosures on business model and strategy and, where requested by the Board, provide advice in respect of the fair, balanced and understandable statement.
- Assess Quality Accounts disclosures and reporting.
- Consider the content of the Annual Governance Statement.

Internal controls and risks

- Review the internal control and risk management systems (unless expressly addressed by separate board risk committee).
- Explain what actions have been, or are being taken to remedy any significant failings or weaknesses.

Oversight of internal audit

- Monitor and review the effectiveness of the internal audit activities.

Whistle-blowing and fraud

- Ensure that appropriate arrangements are in place for the proportionate and independent investigation of any concerns that are raised by staff in connection with improprieties.

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 performed our scoping in line with the Code of Audit Practice issued by the NAO as detailed in our planning report.

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. These are set out on pages 17 and 18 of this report.

Determine materiality

When planning our audit we set our materiality at £4.4m based on 2% of planned incoming resources. Materiality has changed since our planning report based on actual results and is now calculated as £4.6m. We report to you in this paper all misstatements above £230k.

Significant risk assessment

In our planning report we 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. No additional risks have been identified since our Audit Plan.

Conclude on significant risk areas

We draw to the Audit Committee's attention our conclusions on the significant audit risks. The results of the testing are set out on pages 8 – 13.

Our audit report

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

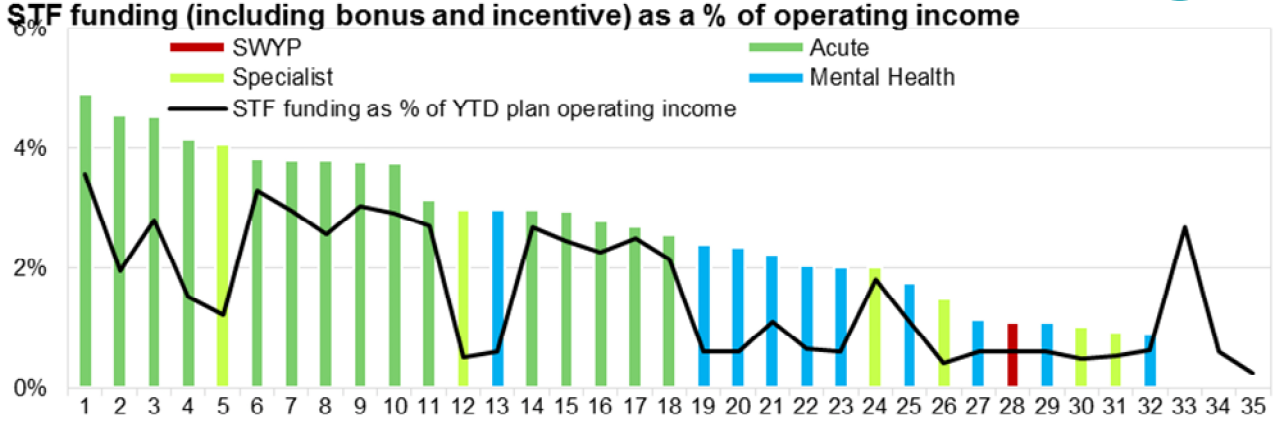
Sustainability and Transformation Funding

The Trust has an STF allocation for the year of £1.35m, with a control total of £1.8m, or £0.5m before STF income. During the year, NHS Improvement announced that unused funds from the STF would be reallocated to Trusts exceeding their control total, matching improved results £ for £ and with any remaining amounts being paid to organisations that at least achieved their control total. The Trust exceeded its underlying control total by £0.2m, however in their letter of 24 April 2017 NHSI awarded £0.41m of incentive STF meaning that with STF funding it exceeded its control total by £1.4m.

Of the £1.35m core allocation of STF for the year, £1.35m has been recognised (100%) compared to an average of 83.2% for all trusts we audit. The Trust has received an incentive payment for exceeding its control total of £0.41m and a bonus of £0.77m to give an overall STF payment of £2.52m, 186.9% of the original core allocation, compared to an average of 151.6% for all Trusts we audit.

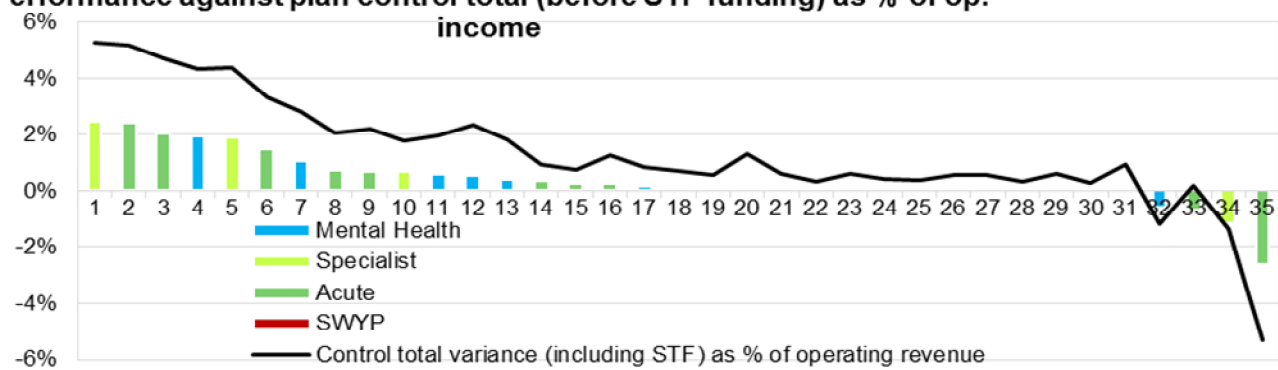
This is 0.6% of the Trust's planned operating income for the year, compared to an average of 1.8% for all trusts we audit and 0.7% for MH trusts. 91% of trusts we audit received incentive and bonus payments with an average incentive of £2.9m, and an average bonus of £1.1m. This has increased the reported performance of Trusts that have achieved their control totals.

STF funding (including bonus and incentive) as a % of operating income



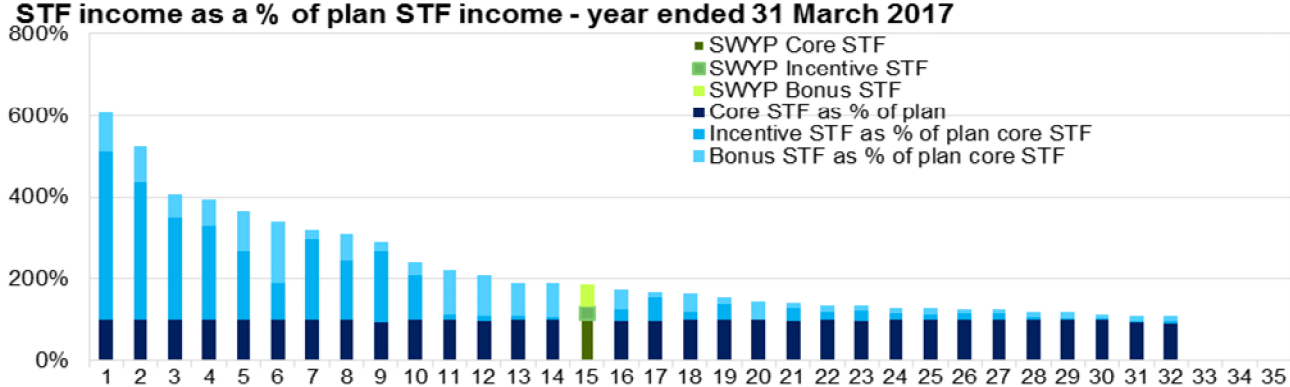
Source: Deloitte analysis of NHSI submissions.

Performance against plan control total (before STF funding) as % of op. income



Source: Deloitte analysis of NHSI submissions.

STF income as a % of plan STF income - year ended 31 March 2017



Source: Deloitte analysis of NHSI submissions.

Significant risks
Dashboard

Risk	Material	Fraud risk	Planned approach to controls testing	Controls testing conclusion	Consistency of judgements with Deloitte's expectations	Expected to be included in the significant issues section of the Audit Committee's report	Expected to be included in our audit report	Slide no.
CQUIN Income	✓	✓	D+I	Satisfactory	●	✓	✓	9
Property valuations	✓	✗	D+I	Satisfactory	●	✓	✓	10
Management override of controls	✓	✓	D+I	Satisfactory	●	✓	✗	11
Agresso Software upgrade	✓	✗	D+I	Satisfactory	●	✓	✗	12
Community Hub Project	✓	✗	D+I	Satisfactory	●	✓	✓	13

Overly prudent, likely to lead to future credit ⊖ ⊖ ● ⊕ ⊕ Overly optimistic, likely to lead to future debit.

D+I: Testing of the design and implementation of key controls

Significant audit risks

Revenue recognition in respect of CQUIN Income

Risk identified	The risk of fraud in revenue recognition is a presumed risk under International Standards on Auditing. We have identified the recognition of CQUIN income as a key risk due to judgemental nature of this income. 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.
Deloitte response	The key judgement in the recognition of the revenue is assessing whether the relevant performance criteria have been met. We are completing our work in respect of a retrospective review of the accuracy of managements estimation techniques used in the application and allocation of CQUIN income and are challenging this. • We have 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 have reviewed the Q4 estimate of CQUIN income and have agreed this to supporting information from the Trust on activity performance.
Conclusion	We have completed our testing of CQUIN income, and have noted no issues in relation to this. However, as the Q4 amount is still in the process of being finalised with the commissioners we have included a representation, within the management representation letter, that there are no disputes in relation to the Q4 amount that we have not been made aware of.
Inclusion in our audit report	We will refer, 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

Accounting for Property valuations

Risk identified	The Trust is required to hold property assets within Property, Plant and Equipment at valuation, which will usually be on a modern equivalent asset – alternate site basis. As detailed in our Audit Plan, 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 Trust had an independent valuation carried out for the purposes of the 31 March 2017 financial statements. Where existing properties are being modernised, the "modern equivalent asset – alternate site basis" valuation rules can lead to a "day one" impairment where the accumulated cost of the asset exceeds the cost of a newly built facility.
Deloitte response	• We have reviewed the Trust's capital and valuation plans as part of the planning processes 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 2017 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. From our review of the initial report we identified that the DV had used the incorrect BCIS figures in the valuation, following discussions with management and the valuer, an updated report using the correct BCIS figures was issued. We are satisfied that the work completed by the DV is of a reasonable standard and that the key assumptions are appropriate. We have identified an uncorrected misstatement with the valuation, due to the movement on BCIS figures from 31 December to 31 March. Please refer to page 25.
Conclusion	We have completed the work in relation to property valuations, and have raised two insights detailed on page 17 and one adjustment as detailed above.
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	In accordance with ISA 240 (UK and Ireland) management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions. The key judgements in the financial statements are those which we have selected to be the significant audit risks revenue recognition and valuation of the Trust's estate. These are inherently areas in which management has the potential to use their judgement to influence the financial statements.
Deloitte response	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 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; and • considered the rationale for the accounting estimates and assessed these for biases that could lead to a material misstatement due to fraud.
Conclusion	We have completed our testing of journals and have not found any instances of inappropriate override of control in our sample. 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 or those charged with governance.
Draft audit report findings	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 identified	Agresso is the Trust's integrated financial ledger system and, during 2016/17, the Trust has upgraded the system to a new version. This upgrade included migration of the underlying databases from the old system to the new. The migration of the financial data, if done in an uncontrolled manner, could result in a material error which could be pervasive to the financial statements.
Deloitte response	There is little judgement involved in this risk however there is significant scope for error: • we have assessed the closing and opening trial balances from the old and new systems to confirm that all codes are included and that, in both cases, the correct cut over date is selected; • we have used analytical tools to compare the closing trial balance per the old and new system; and • we have used analytical tools to compare the migration data load of the new system to the old system and investigate any significant differences.
Conclusion	We are satisfied with the data transfer of the opening and closing trial balance and the data load from the old system to the new system.
Inclusion in our audit report	We do not expect to include this risk in our audit 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

Community Hub Project completion and ongoing work at Chantry and Trinity

Risk identified	The Trust has had an extensive £12.3m capital programme, including £6m of spend on the Fieldhead development and £2.5m on the Wakefield and Pontefract Hubs. There is a risk around the valuation of these assets during the construction phase including whether costs should be capitalised and when the asset should be brought into use, and hence 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 – alternate site basis" valuation rules can lead to a "day one" impairment where the accumulated cost of the asset exceeds the cost of a newly built facility.
Deloitte response	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 under construction to operational assets during the year and reviewed the valuation and depreciation treatment of these transfers. • We reviewed managements assessment of impairments to the value of cost held in assets under construction. • We reviewed managements 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 10.
Conclusion	We have received managements assessment of the valuation of the Fieldhead masterplan site as at 31 March 2017 and deem it to be 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.

Value for Money (VfM)

We have concluded satisfactorily upon identified VfM risks and do not anticipate making any reference in our report.

Value for Money

We are required to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. VfM is assessed against the following criterion, and three sub-criteria (informed decision making, sustainable resource deployment, and working with partners and other third parties):

"In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people."

Our work takes account of the Annual Governance Statement and the findings of regulators. We are required to perform a risk assessment through the course of our audit to identify whether there are any significant risks to our VfM conclusion, and perform further testing where risks are identified.

Overall Financial & Quality Performance

As part of our risk assessment, we have considered how the Trust's performance compares to plan and prior year:

	Actual 2016/17	Plan 2016/17	Variance	Prior year 2015/16
Surplus (operating)	£2.6m	£4.9m	(£2.2m)	£0.4m
EBITDA margin	6.2%	4.6%	69.8%	4.4%
CIP target and identified to date	£9.0m	£10.1m	11%	
Single Oversight Framework segmentation	2			
CQC report conclusions	Good*			Requires improvement

*The good rating was confirmed in the CQC's report issued in April 2017.

Risk Assessment work performed

As part of our risk assessment, we have considered information from a combination of:

- "high level" interviews with key staff
- review of the Trust's draft Annual Governance Statement;
- consideration of issues identified through our other audit and assurance work;
- consideration of the Trust's results, including benchmarking of actual performance and the 2017/18 Annual Plan;
- review of the Care Quality Commission's report on the Trust dated June 2016;
- review of NHSI's risk ratings; and
- benchmarking of the Trust's performance.

Conclusion

We identified specific risks in respect of the response to the CQC inspection and the delivery of the transformation programme. These are discussed further on the following pages.

Risks in relation to our Value for Money Opinion

Response to CQC Inspection

Risk identified	The Trust had a CQC inspection during 2015/16. The Trust was rated as "requires improvement". The response to the CQC inspection, if not correctly delivered could impact on the value for money conclusion.
Risk assessment work performed	We have: • reviewed the progress against the agreed action plan arising from the inspection and note that progress has been made in respect of most recommendations; • obtained copies of correspondence with the CQC following the inspection and it is noted that following the re-inspection in January / February 2017 that the overall rating provided to the Trust has been increased to "good"; • interviewed senior officers of the Trust to understand the outcome of any re-inspection and feedback in respect of the re-inspection has been positive; and • reviewed the report from the CQC and note that there is progress against the majority of the recommendations and the number of findings requiring immediate attention has decreased significantly.
Conclusion	Our work has not identified any specific risks or issues relating to the response to the CQC inspection which would have an impact on our Value for Money conclusion. We have not identified any issues which we would need to report in our audit opinion.

Risks in relation to our Value for Money Opinion

Delivery of transformation programme

Risk identified	Whilst the Trust has been able to set a surplus budget for the current year our discussions with officers of the Trust has indicated that the general opinion is that the 2016/17 budget will be difficult to deliver, and will be dependent upon the successful delivery of the transformation programme. We also understand that while there has been slippage in the programme there is confidence within the Trust that the overall financial plan can be delivered through non-recurrent measures.
Risk assessment work performed	We are aware that Internal Audit have not undertaken their planned review in relation to delivery of service change and reviews of support services. Therefore we have undertaken a review of the Trust's medium term financial plan as well as the 2017/18 Operational plan to assess the reliance of the Trust on the delivery of the planned CIP Programme. From this we have performed a sensitivity analysis to review the impact that differing levels of CIP delivery would have on the Trust's financial position and available cash as we all as obtaining the month 1 CIP report to review the current performance against plan. Additionally no residual risks have been identified from the work we have performed over the governance of the overall transformation programme.
Conclusion	Whilst there remains risk to the delivery of the cost reduction plan, the current financial position of the Trust, the governance arrangements that the Trust has in place and the history of good delivery of CIPs (2015/16: 89%) means that we do not consider there to be issues that would have an impact on our Value for Money opinion. We have not identified any issues which we would need to report in our audit opinion.

Other significant findings

Internal control and risk management

During the course of our audit we have identified a number of internal control and risk management findings, which we have included below for information.

Area	Observation	Priority
Valuations of PPE	District Valuer confirmed that the estate was last fully inspected for the December 2013 valuation and that several buildings have been inspected subsequently following significant works being undertaken. Good practice suggest that re-inspection of the portfolio is undertaken periodically and, in our opinion, is becoming overdue. Therefore we recommend that the Trust includes in their instructions to the DVS for next year the need for a re-inspection of the entire portfolio.	
Valuations of PPE	For future years the Trust should, following the establishment of their MEA assumptions and after their appointed valuer has reviewed, and where appropriate, challenged the assumptions, prepare a paper setting out and justifying their MEA assumptions. This should be passed to audit / DRE for review prior to the valuation exercise getting underway. These considerations should then be written up by the valuer and included within the valuation report as there is currently no commentary on the Trust's processes in determining Modern Equivalent Asset assumptions or what checks have been carried out to ensure that the considerations and therefore the valuations are sufficiently robust.	
Finance risk register	It was noted that some of the controls held within the risk register are not controls and are instead actions to be undertaken in order to correct the mistake. The controls listed within the risk register should be assessed and where appropriate rewritten.	
Third Party Assurance	The Trust currently doesn't receive Service Auditor Reports in relation to the IT control environment operated by Daisy (Network) or Servelec (Rio). Therefore, the Trust receive no assurance over the operational of key IT general computer controls including information security, change management and IT operations. We recommend that the Trust should seek to obtain third party assurance from Daisy and Servelec by way of annual service auditor reports.	

Low Priority

Medium Priority

High Priority

Financial metrics benchmarking

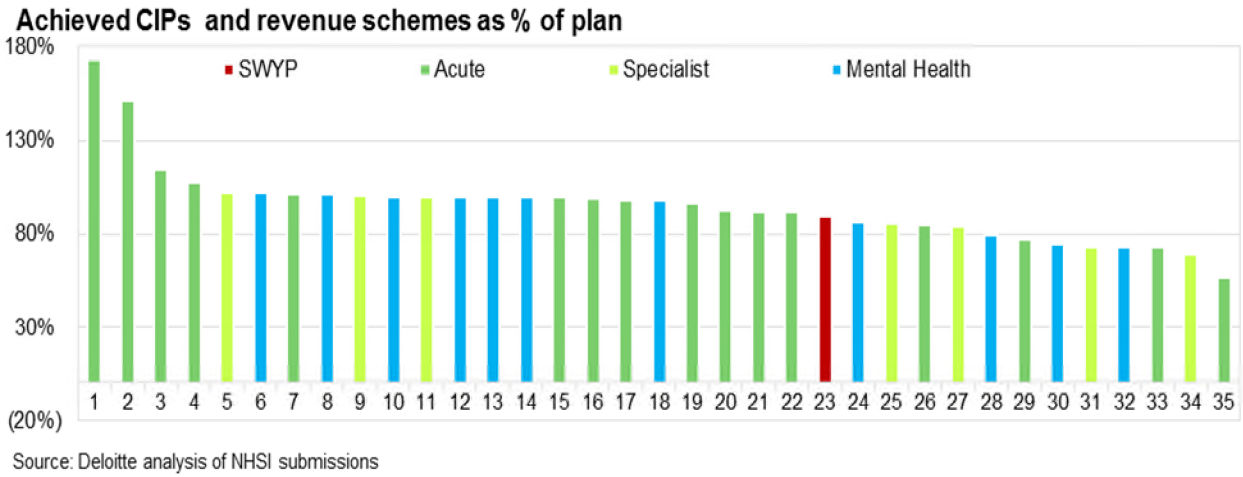
Value for Money

Cost Improvement Programmes

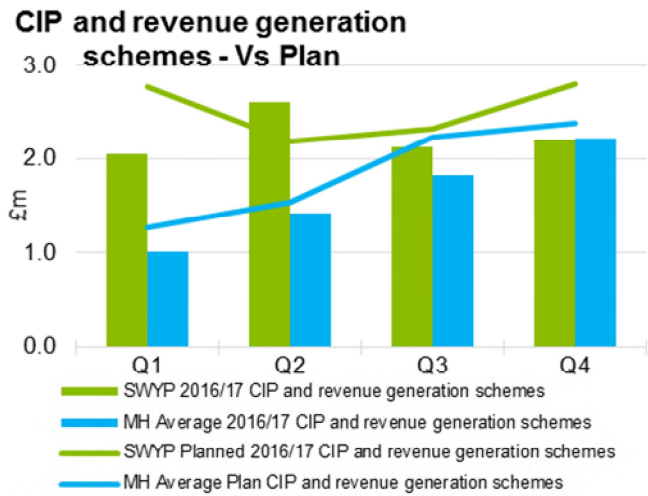
As part of our risk assessment procedures, we considered how the Trust's CIP delivery and programme compares to our other Foundation Trust clients.

CIP and revenue generation schemes %/£m	Trust 2016/17	Mental Health 2016/17	Acute and Specialist 2016/17	All Trusts 2016/17
Plan CIP and revenue generation schemes	£10.1m	£7.4m	£16.7m	£13.5m
Actual CIP and revenue generation schemes	£9.0m	£6.5m	£15.7m	£12.5m
Actual as % of plan, of which:	89%	87%	94%	93%
- Revenue schemes as % of plan	n/a	81%	116%	114%
- CIPs as % of plan	89%	88%	86%	87%
Recurrent CIPs as % of total	52%	74%	73%	74%
Actual CIPs as % of operating expenses	4.0%	3.2%	2.8%	2.9%

On average, the trusts reviewed had planned to increase their level of CIPs (before revenue schemes) from 2.6% of operating expenses in 2015/16 to 3.4% in 2016/17, a 0.8% increase. As shown in the chart and table above, this increased level of CIP has not been delivered, with trusts on average delivering 94% of plan (acute and specialist trusts 93%). The Trust has delivered 89% of plan, an overall £1.1m shortfall.



Source: Deloitte analysis of NHSI submissions



Source: Deloitte analysis of NHSI submissions

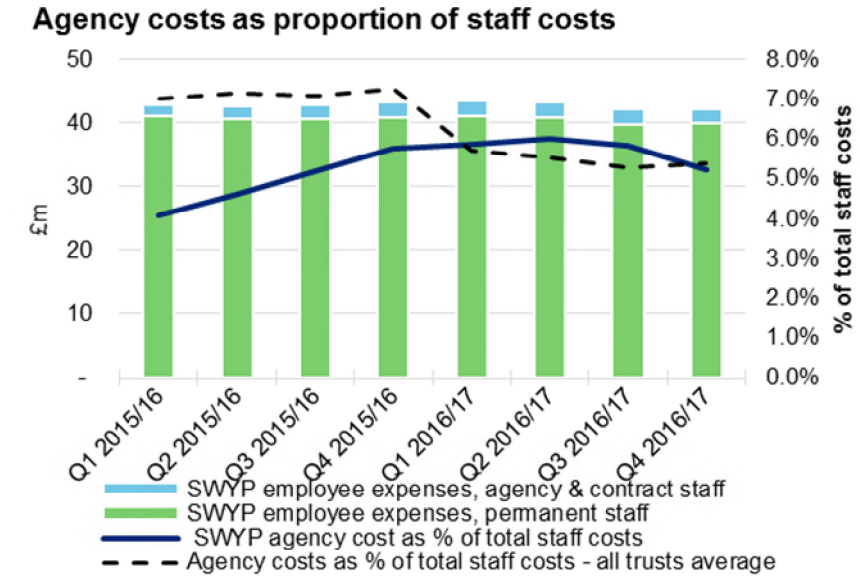
Value for Money

Agency costs

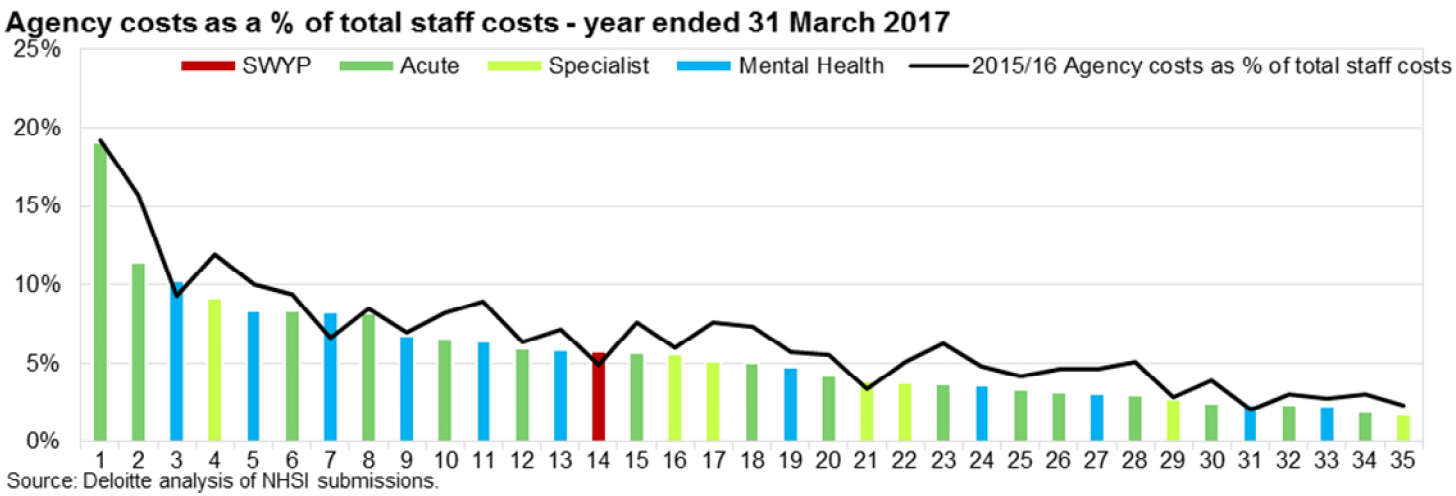
Agency spend has been an on-going area of focus for the Department of Health and NHS Improvement, with a series of initiatives to reduce spending and increased regulatory focus in this area. Nonetheless, as previously noted in our Sector Developments reports, the sector as a whole has continued to spend above plan on agency costs this year.

For trusts we audit, the total overspend for the year was 30% of plan, compared to 61% for the Trust. On average, trusts achieved 87% of pay CIPs, compared to 99% for the Trust.

The Trust's level of agency costs has increased compared to 2015/16 by £1.4m to £9.8m (17%) and £3.7m up on plan (with spend at 161% of plan).



Source: Deloitte analysis of NHSI submissions

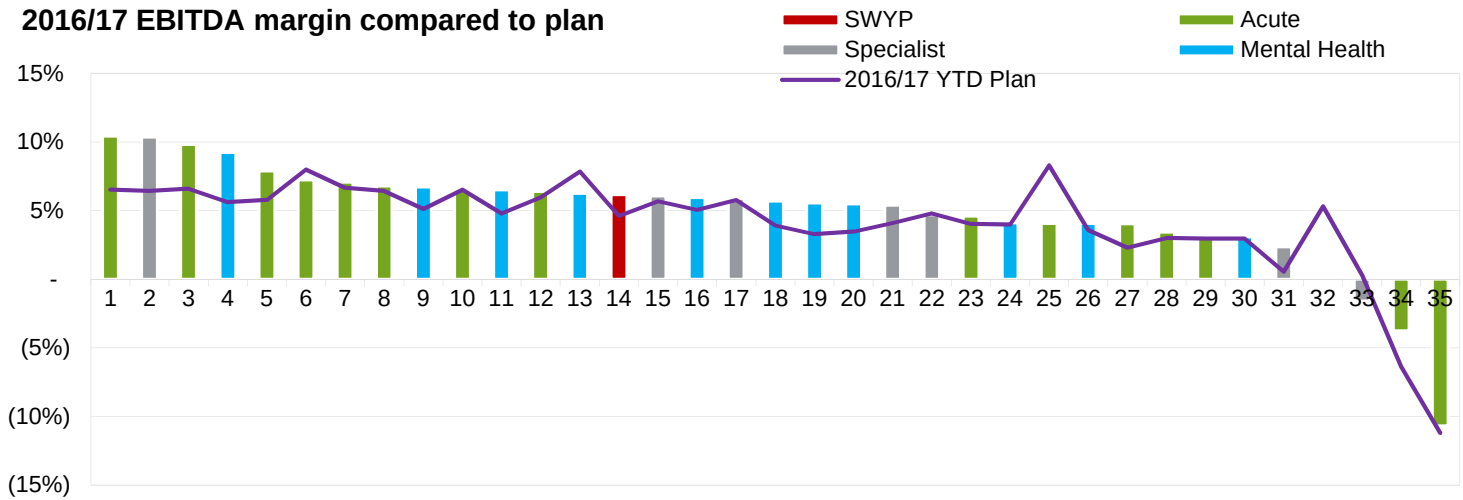


Source: Deloitte analysis of NHSI submissions.

Financial performance

EBITDA

The Trust gap between plan and actual was 0.8% in 2014/15, 0.0% in 2015/16 and -1.6% in 2016/17. The Trust had an EBITDA of 6.2% in comparison to 5.8% for all mental health trusts that we audit.



Source: Deloitte analysis of NHSI submissions

Sector Updates

Managing conflicts of interest in the NHS

NHS England have published new guidance

Issue

NHS England (NHSE) have issued new guidance on managing conflicts of interest in the NHS. The guidance comes into force from 1 June 2017 and applies to all CCGs, Trusts, Foundation Trusts and NHSE. It does not apply to independent or private sector organisations, although NHSE has asked these bodies to voluntarily consider the guidance.

The guidance:

- introduces common rules and principles for managing conflicts of interest;
- provides advice to staff and organisations about what to do in common situations; and
- supports good judgement about how interests should be approached and managed.

The guidance provides definitions for conflicts of interest, and for the different type of interests an individual may hold (financial, non-financial professional, non-financial personal and indirect) to aid in the identification of such interests.

Process and principles for management are outlined, and specific guidance is included for common situations, such as:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership interests
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practise

The guidance also provides information on how to deal with any 'breaches' of the guidance that may occur at an organisation.

Next steps

- The committee and management should consider the guidance and how it aligns with Trust's current conflict of interest policies, including whether any new policies or procedure will require implementation in order to comply with the guidance.

Protecting whistleblowers consultation

The Department of Health (DH) is consulting on new regulations

Issue

The Department of Health (DH) is consulting on its draft Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) regulations.

The intention of the regulations is to give protection from discrimination to an NHS applicant who has previously made, or appears to have made, a protected disclosure under the Employment Rights Act 1996. The regulations follow new legislation in the Small Business, Enterprise and Employment Act 2015 which enabled regulations to be made to protect whistleblowers from discrimination by prospective NHS employer.

The legislation underpinning the regulations was passed following the independent policy review "Freedom To Speak Up", which was commissioned as a result of the 2013 report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, and which exposed unacceptable levels of patient care and a culture that deterred staff from raising concerns. The review had found that 'individuals are suffering, or at risk of suffering, serious detriments in seeking re-employment in the health service after making a protected disclosure'.

The draft regulations have now been published, along with eight consultation questions, with **consultation closing on 12 May 2017**.

The draft regulations aim to:

- Prohibit discrimination by certain NHS employers in the recruitment of an applicant (i.e. by refusing the application or otherwise treating the applicant less favourably than other applicants are treated or would be treated in relation to the same contract post or office) because it appears that the applicant has made a protected disclosure.
- Give the applicant a right to complain to an employment tribunal if they have been discriminated against on this basis.
- Set out a timeframe in which a complaint to the tribunal must be lodged.
- Set out the remedies which the tribunal may or must award if a complaint is upheld.
- Make provision as to the amount of compensation that can be awarded.
- Give the applicant a right to bring a claim in the County Court or the High Court for breach of statutory duty in order to, amongst other things, restrain or prevent discriminatory conduct.
- Treat discrimination of an applicant by a worker or agent of the prospective employer (NHS body), as if it was discrimination by the NHS body itself.

Next steps

- The committee and management should consider whether they wish to respond to the consultation and note the potential impact of the new regulations on their own internal policies and procedures.

The Apprenticeship Levy

Legislation comes into force from 5 April 2017

Issue

From 5 April 2017, employers in the UK with an annual pay bill exceeding £3 million are charged a levy of 0.5% of their 'pay bill' (defined as payments to employees subject to employer Class 1 (secondary) National Insurance Contributions) less a £15,000 annual allowance to be paid via the PAYE process. Amounts paid via the levy can, together with amounts contributed by government, be used to fund approved training/assessment programmes.

Payments made under the levy are credited to the employer's account, maintained on the government controlled 'Digital Apprenticeship System' (DAS). Employers need to register for the DAS in order to access the funds paid into the account. Funds paid into a DAS account are immediately available to fund apprenticeship training for/assessment of existing employees or new hires that is:

- provided by a government approved training provider/assessment organisation;
- working towards achieving an approved apprenticeship standard or apprenticeship framework;
- at least 12 months in duration; and
- involves the apprentice spending at least 20% of their time in 'off the job' training, alongside learning job-specific skills and working with experienced staff.

Payments to a training provider are made directly by government, with a concurrent reduction in the DAS balance. There is no circumstance in which the employer can recover cash from the DAS.

Amounts paid into the DAS expire after 24 months, with payments to training providers allocated on a FIFO basis (i.e. a payment made to a training provider is allocated first to the oldest payment into the DAS). Upon expiry of funds in the DAS, the employer receives no refund or other benefit of any kind.

Government will also contribute directly to apprenticeship costs in two ways:

- By a 'top-up' into the employer's DAS account of £1 for every £10 paid in through the levy system. Once the 'top-up' is made, there is no distinction between that amount and amounts paid by the employer.
- When costs are incurred but there are insufficient funds in the employer's DAS account, by 'co-investment' in which the government effectively share the cost of training and assessing apprentices by paying 90% of approved apprenticeship costs.

The Apprenticeship Levy (Continued)

Accounting for the apprenticeship levy

Issue (Continued)

Although the Department has not yet provided guidance on the accounting, we have summarised below the expected treatment. Future guidance in the GAM may provide specific instructions on presentation, or on how transfers of funds will work.

Accounting for Apprenticeship Levy payments

The accounting for the funds paid into the DAS will differ between:

- Employers that will enter into apprenticeships eligible to be paid for via DAS (expected to cover most NHS providers) and;
- Employers that do not intend to enter into apprenticeships eligible to be paid for via DAS.

For employers with qualifying apprenticeships, the payments are a prepayment for future training services, and the payment is recognised as an asset until the receipt of the service. When the training service is received, an appropriate expense will be recognised.

For employers paying the levy that do not intend to enter into applicable apprenticeships within the 24 month life of funds in the DAS, the levy should be expensed in the same way as other payments to government with no direct benefit received in return.

Accounting for associated government assistance

The additional 10% government contributions are accounted for as government grants. The grant income should be recognised at the same time as the related expense.

In practice, unless the levy is spent in full each month, it will be necessary to draw a distinction between funds from the employer and funds that are part of the 10% 'top-up' from government. As the DAS system makes no such distinction then, in the absence of any guidance in IAS 20, a consistent accounting policy will need to be applied. There is currently no central guidance on the appropriate accounting policy for trusts.

Transfers of funds

The scheme allows for the transfer of DAS funds to other bodies within an organisation's supply chain. However, there are currently limited details from HMRC on how transfers will work, and so there is not yet clarity on the required accounting. This may be relevant for some NHS organisation

Next steps

- The Trust should budget for the impact of the Levy from 2017/18 and consider the related accounting requirements. We would expect that generally Trusts will be running relevant apprenticeship and training schemes and as such will need to account for the levy as a prepayment. Absent central guidance, the Trust will need to consider the accounting policy for the sequence of use of funds in the account.
- Many organisations are considering whether practical changes to their current training arrangements can increase the proportion of activity that qualifies to use DAS funds.

Appendices

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:

- Results of our work on key audit judgements and our observations on the quality of your Annual Report.
- Our internal control observations.

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.

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

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" circulated to you in October 2016.

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.

This report has been prepared for the Audit Committee, 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.

Deloitte LLP

Chartered Accountants

Newcastle Upon Tyne | 23 May 2017

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). The net impact of these is to increase profit in the current year by £0.1m, increase net assets by £1.4m, decrease retained earnings by £0.5m and increase current year reserves by £1.3m.

		Debit/ (credit) income statement £m	Debit/ (credit) in net assets £m	Debit/ (credit) prior year retained earnings £m	Debit/ (credit) in reserves £m
Misstatements identified in current year					
Revaluation movement	(1)	(0.477)	1.770		(1.292)
Assets held for sale	(2)	0.253	(0.253)		
Misstatements identified in prior years					
Cumulative effect of prior year misstatements		(0.529)		0.529	
Aggregation of misstatements individually < £0.230m					
Misstatements < £0.230m		0.083	(0.083)		
Total		**(0.67)**	**1.434**	**0.529**	**(1.292)**

(1) Judgemental difference noted on revaluation movement in indices between the valuation date (31 December) and the year end (31 March), we have also calculated a notional split based on the other in year adjustment between the revaluation reserve and the I&E for illustrative purposes.
(2) Judgemental difference on the value of Castleford and Normanton District Hospital based on the contract drawn up for the sale

There has also been some reanalysis to the primary statements within property, plant and equipment.

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
Up to the date of this report we have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management.		

Other disclosure recommendations

Although the omission of the following disclosures does not materially impact the financial statements, we are drawing the omitted disclosures to your attention because we believe it would improve the financial statements to include them or because you could be subject to challenge from regulators or other stakeholders as to why they were not included.

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
Up to the date of this report we have not identified any significant disclosure deficiencies in the annual report and the deficiencies identified have been corrected by management.		

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 are not aware of any fraud or suspected fraud 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 your organisation.

During course of our audit, we have had discussions with management and those charged with governance and no instances of fraud have been identified.

In addition, we have reviewed management's own documented procedures regarding fraud and error in the financial statements

Independence and fees

As part of our obligations under International Standards on Auditing (UK and 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 fees charged by Deloitte for the period have been presented on page 34.
Non-audit services	In our opinion there are no inconsistencies between APB Ethical Standards for Auditors and the Trust'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	We have no other relationships with the Trust, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties.

Independence and fees

The professional fees expected to be charged by Deloitte for the period from 1 April 2016 to 31 March 2017 are as follows:

	Current year £	Prior year £
Financial statement audit (including the Value for Money conclusion)	51,672	51,672
Total audit	**51,672**	**51,672**
Review of Trust's financial plan	20,000	18,000
Review of RiO implementation	-	15,000
Well led governance review	-	59,054
Total assurance services	**71,672**	**143,726**
Independent Examination of Charitable Funds	828	828
Total fees	**72,500**	**144,554**

Deloitte.

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NHS
South West Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Findings and Recommendations from the 2016/17 NHS Quality Report External Assurance Review

Contents

Executive Summary

We are in the process of completing our Quality Report testing

Status of our work

- We have completed our review of the mandatory and local indicators, and undertaken our recalculation of the figures included in the Quality Accounts.
- We have reviewed the draft Quality Report and have not identified any concerns to date regarding the content and consistency of the document.
- We have still to receive the final signed Quality Report and letter of Representation at which point we will issue our final report to the Council of Governors.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".
- Following satisfactory resolution of our outstanding queries we expect to be able to issue an unqualified opinion on the Quality Account.

Single Oversight Framework Rating: 3

The Care Quality Commission re-inspected the Trust in January/February 2017 and gave it an overall rating of 'Good'.

	2016/17 (draft)	2015/16
Length of Quality Report	74 pages	82 pages
Quality Priorities	3	7
Future year Quality Priorities	18	7

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement'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 '100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital' and 'Minimising delayed transfer of care' as its publically reported indicators – the alternative was 'Admissions to inpatient services had access to crisis resolution home treatment teams'.
  - For 2016/17, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected 'Decrease in CAMHS wait times'.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators to the Council of Governors; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested (above), 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 '100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital' and 'Minimising delayed transfer of care' indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.

Executive Summary (continued)

We have not identified any significant issues from our work.

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have substantially completed our content and consistency review. From our work to date, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017 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?	Yes
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)?	Yes

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement 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 2017, 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 Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".

Performance indicator testing (continued)

	7 day follow up	DTOC	Wait times
Accuracy Is data recorded correctly and is it in line with the methodology.	B	B	B
Validity Has the data been produced in compliance with relevant requirements.	G	B	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	G	G	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	B	G	G
Recommendations identified?	✓	✓	✓
Overall Conclusion	Unmodified Opinion	Unmodified Opinion	No opinion required

G No issues noted
B Satisfactory – minor issues only
A Requires improvement
R Significant improvement required

Content and consistency findings

Content and consistency review findings

No issues have been noted to date in relation to the content and consistency

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work 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.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	Yes	Length: 74 pages
• Is there an introduction to the Quality Report that provides context?	Yes	
• Is there a glossary to the Quality Report?	Yes	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	Yes	Patient Safety: 7 Clinical Effectiveness: 8 Patient Experience: 3
• Has the Trust set itself SMART objectives which can be clearly assessed?	Yes	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	Yes	
• Is there appropriate use of graphics to clarify messages?	Yes	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	TBC	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	TBC	
• Is the language used in the Quality Report at an appropriate readability level?	Yes	

Deloitte view

Overall, the Quality Account provides a concise and thorough view of the position of the Trust in the year. We are awaiting the final version of the Quality Report, and subject to receipt of this and confirmation that our recommendations for amendments have been updated we are satisfied that there are no issues in relation to our content and consistency review. Findings have been raised in relation to the indicators, as noted above.

Particular areas of good practice include:

- The use of graphics throughout the report.
- Concise presentation of information.

Possible areas for improvement next year include:

- Additionally clarity around the current year priorities, such as use of tables for additional metrics.

Performance and Indicator Testing

Care programme approach 7 day follow up

	Trust reported performance	Target	Overall evaluation
2016/17	97.5%	n/a	B
2015/16	97.4%	n/a	Not tested
2014/15	96.9%	n/a	B

Indicator definition and process

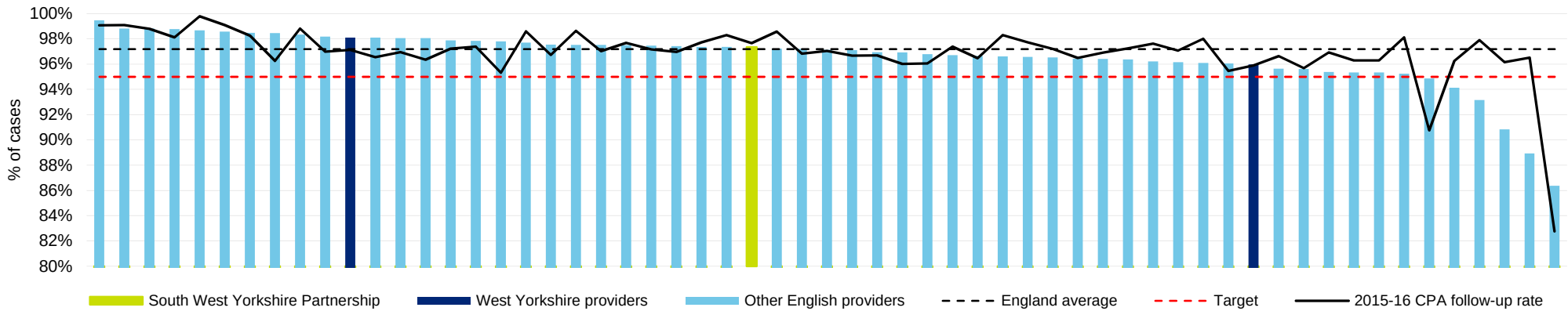
Definition: "The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period."

Patients who are discharged from a mental health in-patient episode on a Care Programme Approach should receive a follow-up contact within seven days of the discharge. Relevant discharges include patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care. All avenues must be exploited to ensure that the patients are followed up within seven days of discharge.

National context

The chart below shows how the Trust compares to other organisations nationally for the first three quarters of 2016/17, the latest national data available.

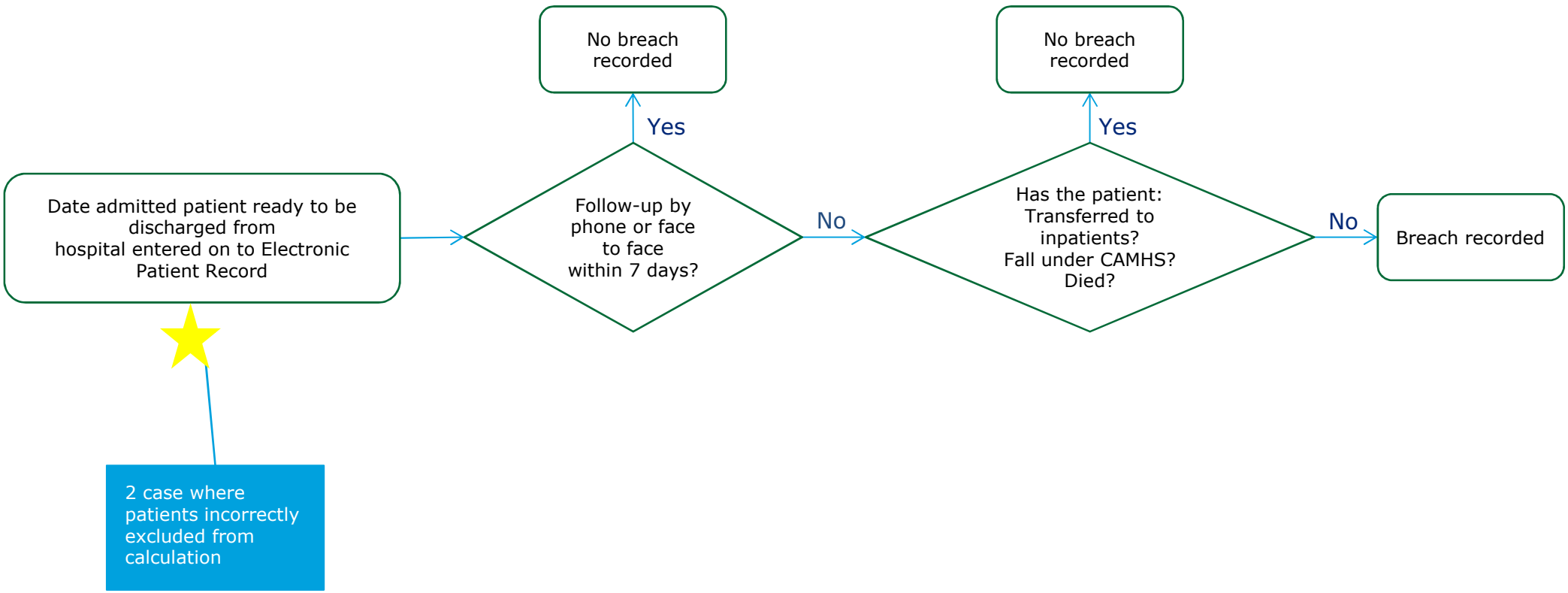
Care Programme Approach patients receiving follow-up within 7 days - 2016-17



Source: Deloitte analysis of Health and Social Care Information Centre data

Care programme approach 7 day (continued)

Process flow



Care programme approach 7 day follow up (continued)

Approach

- We met with the Trust's leads to understand the process from discharge of a service user to the overall performance being included in the Quality Report.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2016 to 31 March 2017 including in our sample service users who had and had not been followed up within 7 days and a sample of 25 service users who had not been included in the indicator.
- We agreed our sample to the underlying information held within RiO and patient notes.
- We recalculated the indicator presented in the Quality Account using data provided to us.

Findings

- 2 instances where cases were excluded from the calculation but should have been included, in both cases there had been a follow up within 7 days.

Deloitte View:

We have completed our detailed testing of the indicator, and have recalculated the percentage shown in the Quality Accounts.

Based on the level of testing that we have performed we do not consider the error in relation to completeness to be indicative of a material misstatement of the indicator and therefore we intend to issue an unmodified opinion.

Delayed transfers of care

	Trust reported performance				Target	Overall evaluation
	Q1	Q2	Q3	Q4		
2016/17	1.92%	2.76%	3.31%	2.86%	**<7.5%**	B
2015/16	2.00%	2.95%	2.54%	2.34%	**<7.5%**	B

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:

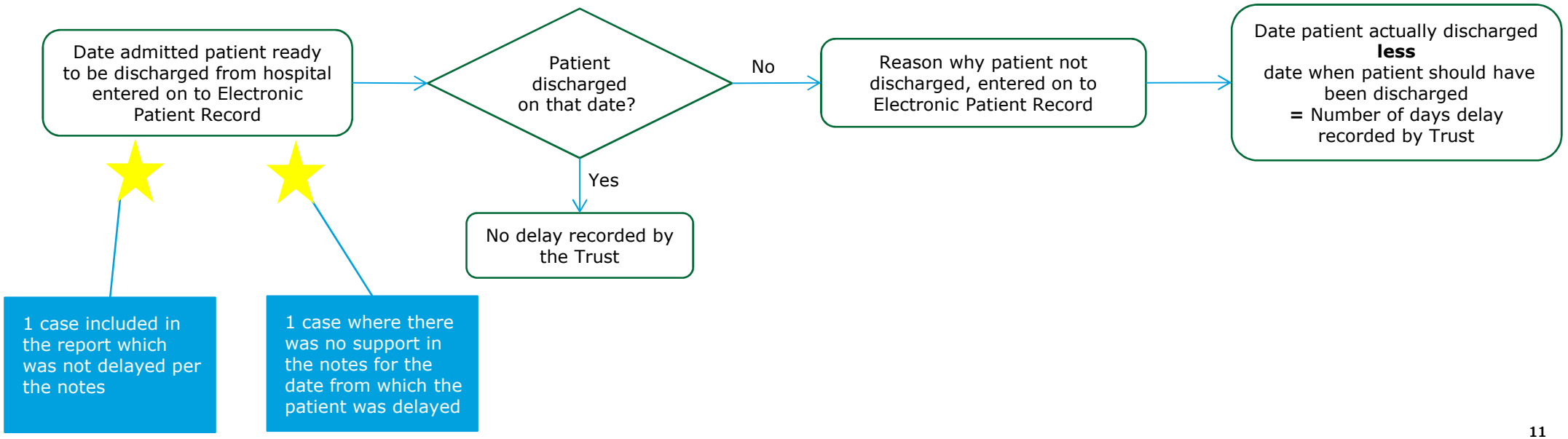
[a] a clinical decision has been made that the patient is ready for transfer AND

[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.

Process flow



Delayed transfers of care (continued)

Approach

- We met with the Trust's leads to understand the process from an individual being ready to transfer care to the overall performance being included in the Quality Report.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2016 to 31 March 2017 of delayed and a sample of 25 delay free transfers of care.
- We agreed our sample to the underlying information held within RiO.
- We have recalculated the indicator presented in the Quality Account using data provided to us.

Findings

- 1 instance where there was no support in the patient notes for the date that the patient was listed in the report as delayed from.
- 1 instance where a patient was included in the indicator but was not noted as being ready for discharge in the patient notes.

Deloitte View:

We have completed our detailed testing of the indicator, and have recalculated the percentage shown in the Quality Accounts.

Based on the level of testing that we have performed we do not consider the error in relation to completeness to be indicative of a material misstatement of the indicator and therefore we intend to issue an unmodified opinion.

Decrease in CAMHS waiting time

	Trust reported performance	Overall evaluation
Jan/Feb 2016/17	67	B
Jan/Feb 2015/16	162	Not selected

Indicator definition and process

Definition: Comparison of average waiting time for generic CAMHS patients seen in Kirklees CCG area in January and February 2016 against those seen in January and February 2017. Start of wait is when the referral is received by the Trust and the wait ends when the patient has their second face to face contact.

Reason for testing: selected by the Council of Governors to validate the decrease.

Context

With the introduction of the Single Point of Access (SPA) in the Kirklees area there has been a substantial reduction in the wait times faced by individuals referred to SWYPFT as it is on the more complex cases that should be being referred to SWY as the provider of the specialist service.

Process flow

- Individual contacts the SPA, who will undertake the initial discussion and decide where to send the individual depending on the complexity of their needs, with the more complex cases being referred to SWYP FT.
- Weekly meeting between the SPA and SWYPFT to discuss any potential referrals.
- If SWY take the referral they will take the handover document from SPA back with them and the individual will be added to the system the same day.
- For urgent cases they will be rung through from SPA – conversation over the phone and register the referral seen the next day or within 5 days – information sent in a secure email.
- All contacts are put on RiO as an appointment in the diary and then get outcomed once the meeting has happened.
- Shared list of appointments that have not had the outcome marked at the end of the month to pick up any that have been missed.
- Documentation of the outcome of the appointment stops the clock rather than the appointment and it has to be direct (i.e. face to face).
- Clinician should document the outcome of the appointment themselves.
- Run monthly report at same time as the report of appointment where the outcome has not been documented which provides waiting times.

Decrease in CAMHS waiting time (continued)

Approach

- We met with the Trust's leads to understand the process from identifying the wait times to the overall performance being included in the Quality Report. There were no recommendations from the review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 23 from 1 January 2016 to 29 February 2016 and a sample of 17 from 1 January 2017 to 28 February 2017 March 2017 which in both cases was 100% of the population.
- We agreed our sample to the underlying information held within RiO and the patient notes.
- We have recalculated the indicator presented in the Quality Account using data provided to us.

Findings

- One instance where an outcome for an earlier appointment was not recorded in the patients diary, which would have reduced the reported wait time.
- One instance where the clock was stopped due to direct contact with the parent in relation to the treatment of their child.
- 6 instances across both samples where the 'face-to-face' box in the system has been ticked which stops the clock, however the patient notes and diary show that that contact was via a telephone call.

Deloitte View:

Our testing is complete and management have updated the indicator for the cases noted above where the waiting time had been stopped based on a telephone call and the case where an earlier appointment had not been included.

Recommendation for improvement

Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
7 day follow up	**Incorrectly excluded cases** We recommend the Trust research and understand the reason for the cases which were missed from the report.	We will review our process with the aim to understand how this error occurred. We will instruct our staff on the outcome of our findings and implement any necessary changes. **Responsible Officer:** Head of Performance **Timeline:** 30th June 2017	M
DTOC	**Capture of MDT decisions** In line with our recommendation in the prior year, we recommend that the Trust improve the consistency of its recording of MDT decisions.	We will ensure all clinical teams are reminded of our standards for DTOC recording. **Responsible Officer:** Assistant Director of Nursing and Quality & BDU management teams. **Timeline:** 31st July 2017	M
Wait times	**Recording of direct contact** We recommend that the Trust ensure that staff are documenting outcomes consistently.	Teams will be reminded of the need to accurately record direct/ non – direct contacts accurately. **Responsible Officer:** Senior Management Team- Kirklees CAMHS **Timeline:** 30th June 2017	M

Update on prior year recommendations

Our prior year recommendations have been followed up by the Trust as follows

Indicator	Prior year finding	Deloitte Recommendation	Management response Current year status
DTOC	**Capture of MDT decisions**	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 reemphasised to the ward teams.	Complete - Ensured that all clinical teams are reminded of the standards for DTOC recording.
Care Plan within 28 days	**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.	Complete - Reviewed the methodology for the clinical record keeping audits and consider the points suggested and updated our clinical record keeping audit guidance to ensure teams are clear of the methodology.
Care Plan within 28 days	**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.	Complete - 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.
Care Plan within 28 days	**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.	Complete – Made the age of the performance data clear in the Quality Account report for 2015-16
Care Plan within 28 days	**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.	Complete - Taken into consideration when improving the methodology of the clinical record keeping audits

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 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.

Other relevant communications

- 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

Newcastle
24 May 2017

Deloitte.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 7.2

Title:	**NHS England Managing Conflicts of Interest Guidance / Standards of Business Conduct**
Paper prepared by:	Director of HR, OD and Estates
Purpose:	NHS England have issued new guidance for the NHS organisations on managing conflicts of interests (https://www.england.nhs.uk/ourwork/coi/). This paper is designed to summarise the guidance and confirm the Trust's response.
Mission/values:	The NHS as a whole spends a large amount of public money and therefore it is vital that this is done in the best interest of the population served. The Trust's Standards of Business Conduct policy, which is supported by NHS England's guidance, is designed to ensure that all staff are clear about the importance that decisions are seen to be arrived at without undue influence. This policy supports all the Trust's values but in particular the commitment to be honest, open and transparent.
Any background papers/ previously considered by:	The Trust has an approved policy on the Standards of Business Conduct which forms part of all staffs contracts of employment. There are separate Conflicts of Interest policies for the Trust Board and Members' Council.
Executive summary:	The Trust's Standards of Business Conduct policy sets outs clear expectations and responsibilities of staff whilst at work and in summary these are: Staff of the Trust are expected to: ➢ Ensure that the interest of patients remains paramount at all times; ➢ Be impartial and honest in the conduct of their official business; ➢ Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money. Staff have a responsibility not to: ➢ Abuse their official position for personal gain or to benefit their family or friends; ➢ Accept bribes; ➢ Seek to advantage or further private business or other interests, in the course of their official duties The new NHS England guidance on managing conflict of interests aims to: ➢ introduces common principles and rules for managing conflicts of interest ➢ provides simple advice to staff and organisations about what to do in common situations ➢ supports good judgement about how interests should be approached and managed NHS England's guidance defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

	It goes on to set out the categories of interests: ➢ **Financial Interests**: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making. ➢ **Non-Financial Professional Interests**: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career. ➢ **Non-Financial Personal Interests**: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. ➢ **Indirect Interests**: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making The guidance also details principles, rules and the declaration process for the following areas: ➢ Gifts ➢ Hospitality ➢ Outside Employment ➢ Shareholding and other ownership interests ➢ Patents ➢ Loyalty interests ➢ Donations ➢ Sponsored events ➢ Sponsored research ➢ Sponsored posts ➢ Clinical private practice The new guidance covers areas already within the Trust's Standards of Business Conduct policy but provides more detail advice on common situations that can occur within the NHS. The Trust's Standard of Business Conduct policy is compliant with the new guidance on managing conflicts of interest. However, there are differences in terminology and the new guidance does give helpful examples of where conflicts can arise and what to do in those circumstances. The recommendation is that whilst the Trust is compliant with the new guidance we should look to develop a new policy which standardises the terminology and incorporates relevant examples. There is no change to the Equality Impact Assessment (EIA) of the current policy. The new policy will have an updated EIA when developed. **Risk appetite** As the Trust's Standards of Business Conduct policy is compliant with the new guidance there is no change to any identified risks and it remains consistent with the agreed risk tolerance.

Recommendation:	**Trust Board is asked to NOTE that there is new guidance issued by NHS England on managing conflicts of interest; and that the Trust's Standards of Business Conduct policy will be updated to ensure the terminology is consistent and relevant examples are incorporated.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 7.3

Title:	**Quarterly report on Safe Working Hours Doctors in Training**
Paper prepared by:	Medical Director/Deputy Chief Executive
Purpose:	To inform the Board of the process for monitoring safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report.
Mission/values:	Provision of out of hours clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider mental health system.
Any background papers/ previously considered by:	Briefing paper presented to Trust Board on 25 April 2017.
Executive summary:	The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. In order to ensure that concerns raised during the negotiation process about the potential for unsafe working practices to be introduced, a specific role has been developed in order to oversee Doctors in Training contracts and, in particular, their working hours. The Trust appointed Dr Richard Marriott as the Guardian of Safe Working and the report highlights the following: ➢ Development of a Junior Doctors' Forum to ensure that the views of the Trainees are heard and open communication is developed. ➢ The development of an exception reporting system which allows Doctors in Training to formally raise concerns when they are working outside of their contracted work schedules. The number of exception reports within the first few months was very low and this may have been contributed to by IT challenges in the initial system set up, a reluctance amongst Trainees to raise concerns through such a formal reporting mechanism and positive engagement with the Trainees to address issues as and when they arise. ➢ The Calderdale first on-call rota had to be redesigned in order to be compliant with the new contract regulations and this, combined with functional gaps in the rota, has led to considerable difficulties in the implementation of the rota. Further rota redesign to address these issues is underway. ➢ The setting up of a Trust bank to which all Trainees and other medical staff are able to engage on their commencement of their work in the Trust and can also remain available for future employment. In summary, there is confidence that the new generic work schedules include rota patterns that are compliant with the Terms and Conditions of the new Junior Doctor contract but challenges remain because of the level of vacancies within the on-call rotas, specifically in Calderdale. This risk has been identified and managed within the Kirklees and Calderdale Business Delivery Unit. The rating against risk appetite is currently under review within the BDU.

Recommendation:	**Trust Board is asked to NOTE the report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

QUARTERLY REPORT ON SAFEWORKING HOURS: DOCTORS IN TRAINING

Introduction

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is of paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that the doctors' working hours are safe.

The Guardian is independent of Trust management and the main roles are to:

- Champion adherence to safe working hours
- Oversee safety-related exception reports and monitor compliance with the system
- Escalate issues for action where not addressed locally
- Request work schedule reviews to be undertaken where necessary
- Intervene as required to mitigate safety risks
- Intervene where issues are not being resolved satisfactorily
- Provide assurances on safe working and compliance with TCS
- Submit a quarterly report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Junior Doctors' Forum
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees
- Medical Bank
- Qualitative information
- Issues arising
- Actions taken
- Summary.

High level data

Number of doctors in training (total):	51
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Ad hoc
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Challenges

1) **Workload**: The introduction of the new junior doctors' contract was controversial and has required a considerable amount of additional work by Human Resources (HR) staff without extra resources. Nevertheless, the Trust provided all junior doctors with a generic work schedule prior to commencing work with the Trust or starting on the new contract. HR staff have been extremely supportive of the Guardian role and the process of moving to the contract.

2) **Staff Turnover**: All 3 Postgraduate Administrators within the Trust retired at a similar time just prior to the introduction of the new contract and in some areas, staff unfamiliar with junior doctors' working patterns have had a steep learning curve in managing the rotas. There are plans in place to improve the management and monitoring of rota gaps.

3) **IT System**: The Trust is using the IT system; Doctors Rostering System (DRS) to both develop the rota patterns for junior doctors and manage Exception Reports (ERs). The system has had a number of teething problems and was not ready for use for ERs until the day doctors started on the new contract, so no testing was possible. The system was previously provided free of charge from Health Education England. A charge has been introduced at short notice, from April 2017. The Trust has committed to continue using the system for the next 12 months but will explore alternatives available on the market.

4) **Cost/Salary Implications**: The contract has been largely cost neutral overall but has resulted in considerable changes in salary for different grades of doctor, which may have implications for recruitment in the future.

5) **Trainee and Clinical Supervisor Engagement**: The contract is new to all doctors, many of whom have expressed confusion regarding its implications. To facilitate introduction of the Guardian role and Exception Reporting System, presentations were delivered at the Induction Programme of each cohort of new

junior doctors, the Medical Leaders Advisory Group and the Medical Staff Committee. Briefings were also provided to the Junior Doctors' Forum and the Medical Education Trust Action Group which has oversight of Medical Education issues within the Trust.

6) **Trainee concerns**: Trainees have been reluctant to complete ERs and have expressed anxiety about the Exception Reporting process.

7) **Interaction with other trusts**: a number of our Trainees are employed by partner organisations, one of whom has delayed introduction of the new contract and a number have different systems for Exception Reporting. All Trainees have been asked to use the SWYPFT reporting system whilst in a SWYPFT post.

Development of a Junior Doctors' Forum

The setting up of a Junior Doctors' Forum is a key requirement of the new contract. The forum will meet quarterly and has already met on two occasions in November and February. The role of the forum is to advise the Guardian in all aspects of the role and the focus in the first two meetings has been to agree the Forum's Terms of Reference and to scrutinise the current rota patterns and discuss any concerns raised by Trainees.

All junior doctors within the Trust are invited to the forum but particular efforts have been made to ensure that representatives of all the BDUs and rotas are able to attend. The other key attendees are the Associate Medical Director for Medical Education, Local Negotiations Committee Chair or representative and the HR Business Partner. The local BMA representative has also been invited to attend a meeting but as yet has not been able to do so.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme. The 2nd on-call rotas for each locality are staffed partly by Higher Trainees and partly by non-training Specialty Doctors, the latter being subject to different contracts and terms and conditions.

Tables shown in the appendices demonstrate the breakdown of the different grades of Trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation programme has been good and all posts have been filled. Most GP posts have been filled but due to pregnancy/maternity, there are currently gaps on both the Calderdale and Wakefield rotas. Poor recruitment to Core training posts in Psychiatry has led to a number of gaps with 2 out of the 7 Wakefield posts vacant and 3 out of 10 posts on the Calderdale and Kirklees Core Training Scheme.

Exception Reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20for%20guardians%20August%202016%20v2.pdf.

Each Trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a Trainee is required to work beyond those hours, or if work commitments prevent them from attending required training, the Trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees the ER, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

As the system is new there have, not surprisingly, been only a few ERs completed. The following tables show the ERs by area and doctor's grade, with the third table showing the response time by clinical supervisors. The main issue of note is that the majority have been completed by Trainees in Calderdale. A number of factors have led to the situation in Calderdale being difficult:

1) It is a busy unit.
2) There are only 9 training posts which is only just sufficient to staff the current shift system.
3) A number of the doctors currently in post are unable to do on-call shifts (e.g. due to health issues, pregnancy or lack of experience).

As a result of these problems there are numerous gaps on the rota (see section regarding rota gaps) and the lack of staff means that the remaining Trainees cannot be expected to do all the extra shifts. A meeting has been arranged involving the Guardian, the Clinical Lead, the College Tutor, a Trainee representative and HR to look at potential options to resolve the concerns.

Exception Reports By Area				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	1	1	0
Calderdale	0	4	4	0
Kirklees	0	0	0	0
Wakefield	0	0	0	0
Forensic	0	0	0	0
Total	0	5	5	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	1	1	0
GPVTS	0	1	1	0
CT1-3	0	3	3	0
ST4-6	0	0	0	0
Total	0	5	5	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	1	0	0
GPVTS	0	1	0	0
CT1-3	0	0	3	0
ST4-6	0	0	0	0
Total	0	2	3	0

There have been some issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. The system was still in development as the contract was implemented and there have been a number of issues with the system. A particular problem has been caused by the failure of the

system to send out automatic notifications when an ER is made. All clinical supervisors have addressed the ERs once prompted by myself.

There are still a number of doctors that remain on the old 2002 junior doctors' contract. Historically, the response rate for rota monitoring exercises under the old contract has been poor. It has therefore been decided not to attempt to monitor these doctors' working hours separately. They have all been given access to the DRS system and have been encouraged to complete ERs if they have concerns about their working patterns or hours.

Fines

Should certain of the hours and rest rules under the new contract be broken, a fine may be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to use to improve training within the Trust. None of the ERs received so far have resulted in a fine.

Work schedule reviews

The new contract requires that generic work schedules detailing work patterns and pay be sent to trainees prior to commencement of the post and this was achieved. Following commencement of the post the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post.

The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period. However, as mentioned above, the whole of the Calderdale and Kirklees rotas are under review due to concerns raised both informally and in exception reports.

Rota gaps and cover arrangements

The following table details rota gaps by area and how these have been covered. As discussed, the areas with the most vacancies have the most gaps. However, the numbers of medical staff in Wakefield mean that it has been possible to cover the gaps with Trust staff, in contrast to Calderdale where it has been necessary to use agency staff on a number of occasions. In addition, there were two shifts where it was not possible to obtain junior doctor cover.

At the time of writing, there was no information available on the middle tier rotas that include Higher Trainees.

Gaps by rota Feb/Mar '17					
Rota	Number (%) of rota gaps	Number (%) covered by trainees	Number (%) covered by agency	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	1 (1%)	1 (100%)	0	0	0
Calderdale 1st	28 (24%)	11 (39%)	15 (54%)	0	2 (7%)
Kirklees 1st	5 (8%)	5 (100%)	0	0	0
Wakefield 1st	18 (15%)	16 (89%)	0	2 (11%)	0
Total	52 (13%)	33 (63%)	15 (29%)	2 (4%)	2 (4%)

To date no data has been collated about the financial cost to the Trust of covering rota gaps. Systems are being developed to do so and information should be available in subsequent reports.

Locum work carried out by Trainees

The Trust is largely reliant on the current Trainees to fill the gaps on the rota by undertaking locum shifts. However the number of gaps that have been required to be filled has left staff stretched. Agency staff have therefore been used in Calderdale to fill gaps. Junior doctors were initially concerned that locum pay rates offered under the new TCS were unattractive especially compared to other trusts. After consultation with other Mental Health trusts in West Yorkshire it has been agreed that all locum shifts will be paid at £35/hour.

Previously, no data was collected on how many additional hours an individual doctor worked. The new Postgraduate Administrative staff are developing systems to capture this data. Moving forward, locum cover will be coordinated via the medical bank (see below). As part of the process there will be a check that Trainees offering to do locum shifts have signed an opt-out form for the European Working Time Directive (EWTD). The rules associated with the contract are complicated and administrative staff arranging locum cover will need to be vigilant that individual doctors are not working excessive hours. The DRS system does not flag up when Trainees work beyond safe limits but it is possible that other IT systems may have this functionality.

Medical Bank

There is an on-going process to set up a Trust Bank that all Trainees will be able to join on commencement of work with the Trust. In addition, there have been discussions with the other Mental Health trusts in West Yorkshire aimed at setting up a county wide bank, to increase the pool of doctors that can cover vacant shifts, but this is not likely to be available in the near future.

Qualitative information

Anecdotally it is known that a number of Trainees have been anxious that completion of ERs will be looked upon negatively by supervisors, affecting references or training progression. Reassurances have been given to all the Trainees at induction and at the Junior Doctors' Forum that this will not be the case.

Issues arising

There are a number of issues that arise out of the implementation of the new junior doctors' contract:

1) **Recruitment:** The biggest current challenge and one that is largely out of the hands of the Trust, is recruitment to training posts, particularly Core training posts in Psychiatry. Given that the situation is unlikely to improve in the near future, staff managing the rotas need to be creative as to how we maintain a safe service to our patients while ensuring high quality training and safe working patterns for our Trainees. In particular, the Calderdale 1st on-call rota needs urgent review.

2) **Management of Rota Gaps:** The process for managing rota gaps needs to improve and hopefully the Medical Bank will be a significant step forward in supporting and monitoring this.

3) **Education and Support:** Clinical Supervisors are still getting to grips with their role in the new contract both in relation to development of personalised work schedules and exception reporting. They are likely to require on-going support to ensure that they fulfill the requirements of the new contract.

4) **IT System Issues:** The DRS system was developed at the last minute prior to implementation of the contract and hopefully problems with this will be ironed out. If not, the Trust may wish to consider purchasing an alternative.

Actions taken to resolve issues

Currently the main actions include:

1) Development of the Trust Medical Bank to ensure that a safe service is maintained whilst ensuring that doctors taking on locum work do so in a safe way.

2) Urgent review of the Calderdale rota. Meetings involving key stakeholders including Trainees to find solutions have been undertaken and proposals are being consulted upon.

3) Close working between the Guardian and the Postgraduate Medical Education Coordinator is ongoing to develop systems to support all the clinical leads and rota administrators in understanding the new contract more fully, record important information and allow us to ensure that rotas are managed appropriately.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The main concerns arise out of vacancies and the management of gaps on the rota. Up until now there has been inconsistency in the management of on-call rotas. There has been no system to monitor the impact of vacancies, either financially for the Trust, or from a safety point of view for the individual doctor. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

As described above, most ERs have been generated by staff in Calderdale and the most pressing need is to develop a solution to manage the workload issues there in the context of recruitment difficulties.

Recommendations

Trust Board is asked to note this report and acknowledge that concerns about working patterns, especially in Calderdale, are being managed by the plans currently in place. Any unresolved issues will be included in the next quarterly report.

Appendix

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	3	2	South West Yorkshire Partnership NHS FT
GP Trainee	1	1	South West Yorkshire Partnership NHS FT
CT1-3	4	4	Sheffield Health and Social Care Trust
FY2 FY1	1 1	1 1	Barnsley Hospital NHS Foundation Trust

Calderdale

Grade of Trainee	**Number Expected**	**Number in Post (WTE)**	**Employer**
ST4-6	1	1	South West Yorkshire Partnership NHS FT
GP Trainee	3	3*	South West Yorkshire Partnership NHS FT
CT1-3	4	2.8*	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	1*	South West Yorkshire Partnership NHS FT
FY2 FY1	3 1	3 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

*In post but a total of 3 doctors unable to do on-call

Kirklees

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	1	1	South West Yorkshire Partnership NHS FT
GP Trainee	2	2	South West Yorkshire Partnership NHS FT
CT1-3	6	4	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	2	South West Yorkshire Partnership NHS FT
FY2 FY1	1 1	1 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	4	4.6	South West Yorkshire Partnership NHS FT
GP Trainee	4	2.6	Leeds and York Partnership NHS FT
CT1-3	7	5	Leeds and York Partnership NHS FT
LAS (covering training gaps)	N/A	2	South West Yorkshire Partnership NHS FT
FY2 FY1	2 3	2 3	Mid Yorkshire NHS Trust Mid Yorkshire NHS Trust

Newton Lodge

Grade of Trainee	Number	Employer
ST4-6	3	South West Yorkshire Partnership NHS FT
ST4-6	1	Sheffield Health and Social Trust

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 7.4

Title:	**Update to the Customer Services Policy: management of complaints, concerns, comments and compliments**
Paper prepared by:	Director of Corporate Development
Purpose:	For Trust Board to note that the policy that provides the framework for responding to enquiries and learning lessons from feedback through complaints, concerns, comments and compliments has been reviewed and updated taking account of the information shown in the executive summary below.
Mission/values:	The Customer Services Policy links to all the Trust's values in supporting an improved service user experience through being open honest and transparent, respectful, putting the person first and in the centre, to improve and be outstanding, be relevant today and ready for tomorrow and demonstrating that families and carers matter.
Any background papers/ previously considered by:	Updated policy approved by Trust Board January 2017. Further updated was reviewed and supported for approval by EMT on 15 June 2017.
Executive summary:	The Trust has an established Customer Services function, which works with Business Delivery Units (BDUs) to support a response to all enquiries. This includes a response to issues raised under the NHS Complaints procedures. The Customer Service Policy provides the framework for responding to these enquiries and takes account of relevant legislation and best practice. The policy was reviewed and updated in January 2017 and approved by Trust Board. As part of the Care Quality Commission (CQC) action plan the Trust was asked to include reference to people's right to complain to the CQC about detention under the Mental Health Act – in line with the Mental Health code of practice. Legal service / mental health act colleagues have been consulted about this policy revision. The changes to the policy were agreed at the Executive Management Team meeting on 15 July 2017, there are no additional implications on governance, finance or training. **Risk Appetite** The Customer Services Policy supports the Trust in its endeavours to provide high quality and equitable services, which value and respond to feedback, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the Customer Service policy updated as outlined above with the next review in 3 (three) years unless required earlier.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and internet
Issue date:	December 2013 (V1) December 2014 (V2) January 2016 (V3) January 2017 (V4) June 2017 (V5)
Next review:	June 2020
Approved by:	Trust Board 27 June 2017
Developed by:	Deputy Director of Corporate Development
Director leads:	Director of Corporate Development
Contact for advice:	Customer Services

1. Introduction

The Trust's Customer Services function exists to facilitate a response to all enquiries, and to deal appropriately with feedback. The service operates as a single gateway for raising issues and enquiries, including requests under the Freedom of Information Act. This policy primarily covers feedback about Trust services and the management of complaints, concerns, comments and compliments.

To enable the Trust to provide a responsive, quality public service it is essential to actively seek the views of those people who use our services and to respond appropriately when things go wrong. Complaints handling is a good proxy for an open, transparent and learning culture – which must be evident in a well-led organisation.

The Customer Services policy incorporates the obligations in the NHS Constitution and the Health and Social Care Act. This current version takes account of feedback from the Care Quality Commission inspection and the Customer Services Excellence Accreditation in 2016. It also takes account of national reports, in particular:

- The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England's joint report – My Expectations (for raising concerns and complaints).
- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – which sets out evidence commissioners should be seeking as part of their regular quality assurance processes with providers.

Ensuring that people have opportunity to feedback their views and experiences of care is essential to delivering the Trust values and is part of how we ensure people have a say in public services. Making the process easy is also essential; the Trust recognises that complaints might only arise as a culmination of a number of experiences, so actively encouraging feedback and apologising for negative experience is important.

Dealing with feedback in a transparent and responsive way demonstrates a commitment to improving people's experience of services and to ensuring they get the best possible support. This is built on the duty of candour, mutual respect, effective engagement, excellent customer service and a necessary and proportionate response to issues.

Complaints matter because every concern or complaint is an opportunity to improve and well-handled complaints will improve the quality of care for other people. Failure to deal with complaints appropriately presents a risk to the organisation – a missed opportunity to improve services as a consequence of feedback and an adverse effect on the Trust's public reputation.

The Care Quality Commission's (CQC) expectations mirror the Trust's high standards in terms of listening to and acting on people's concerns. The CQC makes complaints central to its inspection regime and include a lead inspector for complaints (and staff concerns) in large inspection teams. The CQC use the 'My Expectations' outcomes framework in inspections. This is a five-step framework developed by people who use NHS and social care services and describes what a

good complaints handling service experience should look like (more information below).

The CQC use feedback on complaints handling to inform Intelligent Monitoring reports.

2. Purpose and scope

People who use Trust services have a right to have their views heard and acted upon.

The Trust has given a commitment through its mission and values to put the person first and centre and to be honest, open and transparent in all its dealings.

NHS complaints legislation requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person centred approach to ensure that issues are dealt with in a way that people are empowered and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the adoption of the framework which sets out best practice in five steps which is reflected in this policy:

- Considering a complaint – ensuring people are given information about how to complain, that they will be supported to do so and care will not be compromised.
- Making a complaint – ensuring all staff can help, and that making a complaint is easy and convenient.
- Staying informed – keeping people up to date and making the response personal.
- Receiving outcomes – resolving complaints and achieving the appropriate outcome.
- Reflecting on the experience – ensuing complaints are handled fairly and consistently and people understand how their feedback has helped to improve services.

Every member of staff is responsible for supporting people who wish to provide feedback or raise concerns and helping to resolve issues at service level wherever possible. Staff are alerted to customer services processes through promotional activity with services and teams, supported by publicity material and intranet based information. All staff should be able to advise service users, carers, relatives and visitors to the Trust on how to access customer services, including how to make a complaint. Staff assigned to investigate complaints should be supported to take action as appropriate in accordance with Trust policy and procedures and in highlighting necessary learning.

The commitment to learning from people's experience includes:

- Staff empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible.

- The use of insight gained from complaints, concerns, comments and compliments, and other forms of feedback to improve the care provided to service users and carers.
- Thorough and timely investigation of complaints and concerns, and an open and conciliatory response.
- Fair treatment for people who make complaints, and assurance that care will not be compromised in any way.
- Feedback used as essential element of the Trust's approach to Governance.

3. Definitions

For the purposes of this policy, feedback is defined across four categories:

3.1 Compliments

Positive feedback received regarding care received by service users, their relatives and carers.

3.2 Comments

Comments may be made either verbally or in writing to any member of staff within the Trust.

3.3 Concerns

An issue raised verbally or in writing to any member of Trust staff, identifying issues about a service or proposing ways to improve services for the people who use them, their relatives or carers.

3.4 Complaints

The NHS complaints regulations define a complaint as an expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

4. Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Department of Health.

4.1 Who can give feedback?

Any individual can give feedback to any Trust employee, including Customer Services. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carers, relatives, MPs, councillors, advocates and Healthwatch.

4.2 Receiving feedback

The Trust encourages and expects staff to seek feedback and to know how to signpost to Customer Services if that is the person's preference. Customer Services leaflets and posters will be displayed in all service areas.

The Customer Services team can be contacted by telephone, email, via web link, text, in writing or by referral from a member of staff. Corporate social media accounts and external websites (NHS Choices, Patient opinion. Healthwatch) are also monitored to ensure feedback is captured and responded to if possible.

4.3 Acting on Feedback

4.3.1 Compliments

- Compliments can be provided to any member of staff by any member of the public, other members of staff or partner organisations. If a compliment is provided in writing to the relevant ward/department, the manager will respond either by telephone or in writing.
- Thank you letters/cards received by the Chief Executive will be responded to in writing if the author provides contact details. A copy will be forwarded to the appropriate department, ward, manager or staff member with a covering note from the Chief Executive.
- Each BDU is responsible for ensuring all compliments are logged and that monitoring forms are submitted to Customer Services on a monthly basis.

4.3.2 Comments

- Each BDU is responsible for ensuring comments received are reviewed and actioned appropriately, including responding to the person offering the comment.
- BDUs must ensure that service areas log all comments received and that monitoring forms are submitted to Customer Services on a monthly basis.
- Customer Services will respond to comments received directly in liaison with the relevant team.

4.3.3 Concerns and Complaints

4.3.3a Verbal

- Services should invite and welcome feedback.
- Response to concerns and complaints should be *on the spot* wherever possible and a concern report form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from line management. If the concern or complaint is raised verbally, and can be resolved within one working day, the response does not need to be in writing. The issue should be documented using the monitoring form.

- Customer Services will assist as required, offering a named point of contact.

4.3.3b In Writing

- Concerns and complaints received in writing will be reviewed by the Customer Services manager and allocated to a named officer.
- Customer services staff will agree a handling plan with the person raising the issue.
- People will be supported to resolve their concerns either directly with the service or to receive a written response from the Chief Executive.
- Written complaints will always require a formal investigation and written response.

The procedure for complaints handling is detailed in Appendix A.

4.4 NHS Complaint Regulations

The NHS Complaints Procedure covers the following:

- A person who is in receipt of, or who has received, services from the Trust.
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust.
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity, or lack of mental capacity (Mental Capacity Act), or has been requested to act as a service user's representative
- Complaints should be made within twelve months of the incident or becoming aware of the incident that has caused concern. However, this timescale can be extended if the Customer Services Manager is satisfied that there is good reason for any delay and that it is still possible to investigate the complaint effectively.
- When a complaint is made by a representative, the Trust's Customer Services Manager must be satisfied that there are reasonable grounds for a complaint to be made by a third party on behalf of another person. Consent should be obtained from the individual affected.
- All complainants will be informed about the right to access independent complaints advocacy.
- All complainants have the option to apply to the Parliamentary and Health Service Ombudsman, to ask for independent review of their complaint, should they remain dissatisfied following the Trust's management of their complaint.

In line with the NHS regulations, the following are **not** covered by the Trust's Customer Services policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Partnerships Team).
- Complaints about involvement activity (refer to Partnerships Team).
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).

- Complaints about services delivered by an independent provider, on behalf of the Trust, are not covered by the NHS Complaints regulations. However, the Trust must satisfy itself about the quality of service and that the independent provider has its own robust complaints procedure.
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances. These should be raised through appropriate line management processes in line with Human Resources policy.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

4.5 Complaints to other bodies, including the Care Quality Commission (CQC)
People who are, or who have been, detained under the Mental Health Act have the right to complain to the Care Quality Commission (CQC) about use of the Mental Health Act. The CQC will usually ask that the complaint is initially submitted to the hospital managers.

The Mental Health Act Code of Practice (2015) requires information on how to complain to the CQC to be readily available on all wards that are registered to support people detained under the Act. The Trust will ensure CQC material providing the relevant information is available on its wards. Due consideration will be given to the Accessible Information Standard in sharing this information.

5. Duties
The customer services process is supported by:-

5.1 The Customer Services Team
The team will ensure processes that support complaints investigation and resolution, for example the complaints toolkit, remain fit for purpose, support staff to resolve issues, and service users in an effective complaints management process.

When concerns or complaints are received, the Customer Services Manager will:

- Ensure that the complainant is contacted by an allocated team member to explain the process and discuss the handling of the concern/complaint.
- Ensure the complainant is at the centre of the process, and that a complaint management plan is developed, taking account of the complainant's expectations for resolution and negotiated timescale for investigation.
- Alert directors as appropriate to concerns / complaints that suggest quality of care is compromised or other risk assessment is required.
- Ensure written acknowledgement is sent to the complainant within 3 working days.
- Ensure the assigned team member liaises with the relevant clinical lead, manager, or other organisations, to facilitate a response within the agreed timescale.
- Ensure the lead investigator keeps Customer Services updated with the progression of the complaint at all times and at least weekly.
- Receive information from the lead investigator to enable a response to be produced for director review prior to Chief Executive sign-off.

Where more than one organisation (health or social care) is involved, the Customer Services Manager or Deputy Director of Corporate Development will ensure appropriate consent is obtained, and that a lead person is appointed to co-ordinate the investigation and response.

Where complaints received by the Trust relate to another organisation the complaint will be referred on as appropriate, without delay, following receipt of consent from the complainant.

5.2 Director of Corporate Development

The Director of Corporate Development is the lead director for customer services, including complaints management. The Director of Corporate Development will ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery. The Director of Corporate Development will ensure that Customer Services information is reported appropriately to BDUs, in integrated performance reports and in quarterly and annual reports to Trust Board.

5.3 The Chief Executive

The Chief Executive (or nominated deputy) will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

5.4 Medical Director and Director of Nursing, Clinical Governance and Safety

The Medical Director and Director of Nursing and Quality will support risk assessment of complaints and provide objective clinical advice to support the investigation of complaints, either directly, or through clinical leads and practice governance coaches. The Trust's Medical Director will assign investigators where a complaint relates to medical staff. The Nursing Director will ensure appropriate support where complaints highlight professional issues for nursing or allied health professions, or where input from specialist advisors is required.

5.5 District directors / Deputy district directors

District directors (supported by deputies) will ensure appropriate systems are in place to:

- Respond to feedback, investigate concerns and complaints
- Review complaint responses to ensure:
    - Ownership of the response by the service
    - Quality assurance of the response in terms of addressing the root causes
    - Actions are consistently learned and applied across services and in the system.
- Monitor delivery of complaint action plans through BDUs governance processes.
- Provide updates to Customer Services to incorporate in quarterly reports to Trust Board.

5.6 Clinical leads / general managers / practice governance coaches

Working with Customer Services as appropriate:

- Ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues in person or by appointing a suitably skilled member of staff to conduct the investigation.
- Ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit.
- Meet agreed timescales in relations to complaints investigation and management.
- Advise the deputy district director about complaints, and support review of issues and learning through BDU governance processes.
- Ensure any learning for the wider Trust is shared.

5.7 Reporting Feedback

The Customer Services Team and Director of Corporate Development will monitor compliance with this policy and procedure.

The Customer Services Team will provide regular reports to BDUs, advising open and closed complaints in the period and progress on complaints investigation.

The Customer Services Team will provide quarterly reports to Trust Board and to BDUs, covering the number of issues raised, a breakdown of complaints, concerns, comments and compliments, identification of themes and evidence to demonstrate that lessons have been learned as a result of service user feedback. Reports will also include issues referred to the Parliamentary and Health Service Ombudsman, including any financial redress. The quarterly report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with the Members' Council Quality Group for review and information.

The Report will also be shared externally with CCGs through contracting and quality monitoring processes and with Healthwatch across Trust geography.

District Directors will be responsible for ensuring systems are in place to investigate complaints and concerns, that feedback received is reviewed and acted upon, with learning evidenced through governance processes. Insight will be used alongside other sources of feedback to improve services.

The Executive Management Team will monitor key performance indicators (KPIs) in relation to complaints through monthly business intelligence dashboard reporting. The Executive Management Team will also review any action plans arising from complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

An annual report will be produced for consideration by the Trust Board. The Trust Board is responsible for approving Trust policy in relation to complaints handling, for ensuring compliance with national and local targets in relation to complaints, and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved service user experience.

6. Process for monitoring compliance with this policy

The Director of Corporate Development is responsible for monitoring compliance with this policy. This will be achieved through:

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above.
- Routine contact with services and investigators regarding the ongoing process for complaints investigation.
- Feedback from Commissioners.
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsmen, the CQC, the Information Commissioner and NHSI.

Relevant concerns will be reported to the Executive Management Team, with action by the appropriate director.

7. Associated documentation

Supporting procedural documents include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures.
- Being Open policy – including duty of candour.
- Claims Management Policy and Procedure.
- Safeguarding Children procedures.
- Safeguarding adults procedures.
- Health and Safety policies, procedures and processes.
- Human Resources and related policies and procedural and related documents.
- Information Governance (and Caldicott Guardian) related policies and procedural documents.
- Freedom of Information Policy
- Accessible Information Policy
- Communications, Engagement and Involvement Strategy

8. Equality Impact Assessment

This policy promotes equality of access to the Trust's Customer Services function. See Appendix B for equality impact assessment.

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through Customer Services, the availability of information in different formats on request, and promoting access to advocacy and interpreting services.

9. Dissemination and implementation

This policy will be promoted through 'The Headlines' weekly staff bulletin and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Training and support will be offered to staff to underpin the efficient and effective investigation of issues.

Implementation of the policy will be the responsibility of staff at all levels, and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are required to ensure appropriate support is in place for staff impacted by complaints.

BDUs are required to ensure staff who undertake complaints investigation are skilled and supported to do so, to develop action plans to address areas for improvement, and to monitor delivery of same through governance processes.

10. Review and Revision arrangements

This policy and procedure will be subject to annual review by the Trust Board, with review instigated in the event of policy change. See Appendix C.

11. Document control and archiving

This policy will be accessible via the Trust's intranet and website in read only format and managed in accordance with the requirements for retention of non-clinical records. See Appendix D.

Appendix A

Complaints Procedure (Local Resolution)

All complaint investigations should follow the pathway for complaint management as set out below.

- Every effort must be made to support people who wish to make a complaint. This could include language support, support in documenting the issues, signposting to advocacy services or providing mediation.
- Written complaints received by the Chief Executive's office will be notified to Customer Services. Written complaints will be stamped indicating the date received. Written complaints received in other Trust locations should be forwarded to Customer Services in a timely manner (using nhs.net or safehaven fax)
- Complaints will be managed and coordinated by Customer Services in conjunction with the lead investigator. The Customer Services Team will agree the desired outcome with the complainant, contact arrangements and likely timescales.
- Complaints that span two or more organisations will be managed and coordinated by the organisation that has the majority of issues, or the highest risk issues. The lead organisation will coordinate a single comprehensive investigation and response to the complainant. Local working arrangements are in place to support this.
- Complaints received electronically will be coordinated by Customer Services. Contact will be made to obtain the complainants official mailing address and telephone number and an explanation provided that, due to issues of confidentially, the final response to the complaint will be sent in hard copy via the postal system.
- All complaints will be coded and logged on Datix web. Customer Services will maintain up to date Datix web records at all times, recording all activity. Demographic data will also be captured on Datix web, including address and standard equality data.
- All records relating to complaints should be stored confidentially by the Customer Services team, and should be readily accessible via the team if required. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.
- If the complainant requires access to medical records/patient information, Customer Services will provide appropriate contact information in accordance with the Data Protection Act / Access to Health Records Act.
- If the complaint includes a request for information under the Freedom of Information (FOI) Act, the request must be referred to the Customer Services Manager or Deputy Director of Corporate Development to action.
- If a complaint makes reference to a claim for compensation, this will not automatically exclude the issues from being investigated through the complaint process, subject to prejudice to any legal proceedings. Customer Services will work with Legal Services in such cases.

- Complaints will be acknowledged by letter within three working days. Complaints made by third parties will require written consent from the service user before confidential information is released. However, investigation into the issues can commence pending receipt of consent to ensure a prompt response can be offered when appropriate.
- The Customer Services Coordinator will record the progress of the complaint investigation onto Datix web, which will include copies of all correspondence to the complainant, staff, details of telephone calls, face-to-face conversations and electronic correspondence.
- Complaints progression must be maintained in real time by Customer Services staff.
- All records relating to complaint investigation are confidential and must be kept in one master complaint file separate from any medical records. Care should be taken with accuracy, legibility and language used. In accordance with the Data Protection Act (1998), a complainant has the right to access all correspondence contained within the file.
- All complaint records must be kept by the Trust in a secure environment for 10 years.
- Customer Services must maintain contact with the complainant regarding progress and must renegotiate timescales as necessary.
- Consideration must be given to the following:
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or service user safety, the appropriate district director must be informed immediately.
    - Complaints that could fall into the Serious Untoward Incident category (SUI) must be referred for advice to the Patient Safety Support Team. Every effort must be made to minimise distress or confusion to the complainant.
    - Where a complainant indicates they intend to take legal action, the matter must also be referred to the Head of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints / concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate.
    - Complaints about members of staff that involve accusation of misconduct must be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention must be referred to the Communications Team.
    - Issues relating to child protection must be referred to the Trust's Named Nurse for Child Protection, and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults must be referred to the Trust's Vulnerable Adults Specialist Advisor, and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police, and will be supported to do so. If the complainant chooses not to report a serious

matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality.

- Investigators should always alert Customer Services at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

Investigation must be proportionate to the level and complexity of the complaint. The lead investigator will be independent of the service area to which the complaint relates. Investigation will include:

- Meeting with the complainant if appropriate.
- Taking statements from the people involved.
- Ensuring staff involved in complaints are aware of support mechanisms and how to access same.
- Reviewing health care records, policies and procedures as appropriate (documenting evidence to support statements wherever possible).
- Taking expert advice, if needed, for example from specialist functions, Nursing or Medical Directorates.
- Completing the complaints toolkit and forwarding same to Customer Services.
- Ensuring that the evidence in the toolkit addresses all the issues identified.
- Assessing the severity grading of the complaint at the end of the investigation.
- Consideration of the need to reimburse expenses or losses where fault has been identified. This might include, for example, the cost or part cost of lost property or incurred expenses.
- Developing an action plan for every complaint (even where the plan indicates no action required) and forwarding same to Customer Services.
- Ensuring all relevant documents, including staff statements, policy documents and file notes, are collated for inclusion into the complaint file.
- Keeping contemporaneous record of the investigation.

Customer Services will prepare a response to the complainant based on the information provided in the toolkit. Responses will be reviewed in Corporate Development and checked by the relevant director before sign-off by the Chief Executive.

All response letters must inform the complainant of their right to ask the Parliamentary and Health Service Ombudsman to review their complaint if they are dissatisfied with the Trust's response.

Satisfaction surveys will be discussed with or sent to every complainant following the Trust response being offered. Survey feedback will be analysed and taking into account in service planning and delivery.

BDUs (through governance processes) have lead responsibility for delivery of action plans and demonstration of learning from complaint trends, both from BDU and Trust wide issues. Deputy district directors will ensure processes are in place to provide governance and assurance in this area.

Parliamentary and Health Service Ombudsman Review

All avenues must be explored to resolve issues at local level, including further meetings and lay conciliation. However, if a complainant remains dissatisfied after

local resolution they can ask the Parliamentary and Health Service Ombudsman (PHSO) to undertake a review of their case. The PHSO will assess the complaint using the Principles of Remedy, Good Administration and Good Complaint Handling. These principles provide guidance to organisations on how they should handle complaints. The overarching principles are:

- Getting it right.
- Being customer focused.
- Being open and accountable.
- Acting fairly and proportionately.
- Putting things right.
- Seeking continuous improvement.

The PHSO review will seek to demonstrate that the Trust has acted appropriately when assessing the complaint to identify if there is evidence of maladministration or service failure. The PHSO will request the Trust to provide a copy of the complaint file and health care records. After undertaking the review, the PHSO will inform the Trust whether it can close the case without investigation, or whether it intends to progress to formal investigation. Over the past year, the Ombudsman lowered the threshold for investigation and expanded the number of cases considered.

The PHSO has the authority to propose financial remedy to Trusts as a mean of resolving complaints. The Deputy Director of Corporate Development will monitor the impact of this, report on the numbers of cases and financial implications on a case by case basis to the Director of Corporate Development, and reference this in the quarterly complaints reporting to Trust Board and BDUs.

Any action plans arising from complaints upheld or partially upheld by the PHSO will be reviewed by the Executive Management Team with delivery monitored by the appropriate service director.

The PHSO produces an annual review of complaints handling in the NHS and undertakes specialist reviews. The PHSO shares all investigation reports with the relevant commissioning body and NHS England. Learning from these reviews will be shared in the organisation via Customer Services reporting processes.

Unreasonable or persistent complaints
Most complaints are entirely reasonable; however a few are not. Some may, for example, abuse or threaten members of staff or continue to raise the same concerns when these have already been addressed. The following are examples of behaviour which might be regarded as unreasonable:

- Abusive or threatening behaviour – whether in person or in writing.
- Persistent telephone calls or letters on the same issue, which do not allow time for an investigation to be concluded, or do not acknowledge that a response has already been offered.
- Persistent verbal complaints which cannot be resolved through the informal complaints procedure.

Trust staff should acknowledge that, at times, people might find it difficult to express their frustration and might behave in a way that makes resolution difficult. Staff should support people to raise their issues in a constructive manner, manage expectations, and work towards a satisfactory outcome. However, the Trust has a responsibility to protect its staff from people who behave in an abusive or malicious manner, and to avoid inappropriate use of resources through dealing with persistent or unreasonable complaints.

If an investigation lead or customer services co-ordinator becomes concerned that a complainant is becoming unreasonable, they must seek assistance from the Customer Services Manager. It is vital that any restrictions placed on a complainant should be as a result of a fair and consistent process. Any request to cease or limit an investigation about a complaint that is considered unreasonable or persistent, needs to be considered in consultation with the appropriate district director and the Director of Corporate Development.

It may be necessary to request that the complainant only makes contact with a named individual, by one contact method only, for example either by telephone, email or in writing. Where a named individual is assigned they should ensure a comprehensive record of all contact is maintained.

The complainant must be advised that issues already responded to will not be re-opened or re-investigated. If appropriate, the complainant should be informed that abusive correspondence, or threatening behaviour, will not be responded to. The complainant should be offered information regarding independent advocacy support.

Letters or telephone calls received during the formal investigation stage will be acknowledged and any new issues included in the overall investigation. A meeting may be offered to clarify the issues to be investigated and confirm the process. The complainant should be advised if new issues are likely to affect the timescale for providing a final response to the complaint.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

Appendix B

Equality Impact Assessment Template to be completed for all Policies, Procedures and Strategies

Date of Assessment: December 2016

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff
3	**Who is the overall lead for this assessment?**		Bronwyn Gill
4	**Who else was involved in conducting this assessment?**		Corporate Development - Customer Services Team
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Customer services processes and procedures are subject to constant evaluation with service users and carers (following their contact with the team) and with staff following involvement in complaints handling or report review. Information used to inform policy
6	**What equality data have you used to inform this equality impact assessment?**		Protected characteristics data collected via the function.
7	**What does this data say?**		
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	It is not anticipated that this Policy will have any negative impact on any of the equality groups. The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting an allocated caseworker to provide individual support, access to advocacy and / or interpreting services and taking account of information requirements (which will be further enhanced through compliance with the Accessible Information Standard.
8.1	**Race**	**No**	Other mixed } Chinese } Mixed white / Caribbean } White other } 5% Indian } White Irish } Other white background }

			Pakistani – 1% White British – 42% Prefers not to disclose – 53%
8.2	**Disability**	**No**	Sensory impairment – 1% Cognitive impairment – 0% Long standing illness – 4% Learning disability / difficulty – 4% Physical impairment – 5% Mental illness – 20% No disability – 14% Prefers not to disclose – 52%
8.3	**Gender**	**No**	Average % access 57% female 26% male 17% prefer not to disclose
8.4	**Age**	**No**	under 21 – 4% 22 - 31 – 10% 32 – 41– 15% 42 – 51 15% 52 – 61 11% Over 62 – 10% Not disclosed 35%
8.5	**Sexual Orientation**	**No**	Gay – 0% Heterosexual – 13% Lesbian – 1% Bisexual – 0% Unknown/ prefers not to disclose – 86%
8.6	**Religion or Belief**	**No**	No information available
8.7	**Transgender**	**No**	0%
8.8	**Maternity & Pregnancy**	**No**	No information available in the Trust's monitoring data.
8.9	**Marriage & Civil partnerships**	**No**	No information available in the Trust's monitoring data.
8.10	**Carers*** **Our Trust requirement***	**No**	It is not anticipated there will be any negative impact on service users or their carers, feedback is captured through service evaluation.
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		The Policy is subject to annual review.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		The policy promotes equality of opportunity as it provides for a supportive, fair and non-discriminatory approach to customer services and complaints management
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		The Trust is committed to eliminating discrimination in all its forms, including those with protected characteristics
9c	**Promotes good relations between different equality groups;**		The Trust's approach to equality promotes good relations including with those from different equality groups.
10	**Have you developed an Action Plan arising from this assessment?**		No

11	**Assessment/Action Plan approved by (Director Lead)**	**Sign: Dawn Stephenson Date: 23 January 2017** **Title: Director of Corporate Services**
12	**Please note that the EIA is a public document and will be published on the web.**	

Appendix C - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix D - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Dec 2013	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with Francis Report, Patient's Association Report on Complaints and the Rt Hon Ann Clwyd review of NHS Complaints Management.
2	Dec 2014	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with the Francis Report, The Government's response, 'Hard Truths' and the Duty of Candour.
3	January 2016	Deputy Director of Corporate Development	Final	Approved by Trust Board Included updates in line with CQC Essential Standards and PHSO report 'My Expectations'
4	January 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes update in line with: • CQC inspection 2016 • CSE Accreditation 2016 • PHSO report 'My Expectations' • NHSE Assurance of Good Complaints Handling • CQC report 'Complaints Matter'
5	June 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes updates in line with CQC action plan to include reference to people's right to complain to the CQC about detention under the Mental Health Act – in line with the Mental Health code of practice.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017

Agenda item 7.5 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	6 June 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Public Questions at the Health and Wellbeing Board - Procedural Arrangements ➢ Local Plan - Video ➢ Carers Strategy - Presentation ➢ Proposed use of additional Adult Social Care funding (2017-20)
Minutes	Papers and draft minutes are available at: http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	15 June 2017
Non-Voting Member	Dr Adrian Berry/Karen Taylor
Items discussed	➢ Locala Care Quality Commission Report ➢ Calderdale Plan Progress Report ➢ Better Care Fund ➢ Accountable Care Organisation – Discussion Paper and Options Going Forward ➢ Active Calderdale Update
Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=24528

Kirklees Health and Wellbeing Board

Date	The next meeting is scheduled from 29 June 2017.
Invited Observer	Rob Webster/Karen Taylor
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes are available at: https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Wakefield Health and Wellbeing Board

Date	1 June 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Wakefield Troubled Families Programme - Progress Update ➢ Next Steps on the West Yorkshire and Harrogate Sustainability and Transformation Plan ➢ Wakefield Health and Wellbeing Plan Update ➢ Better Care Fund 2017/19 Proposal. ➢ Progressing our model of integrated care across the Wakefield District - Care Homes Vanguard ➢ Connecting Care Executive Update Report
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/residents/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017

Agenda item 8 – Assurance from Trust Board Committees

Clinical Governance and Clinical Safety Committee

Date	22 May 2017
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Consideration and approval of the Quality Account 2016/17.

Date	13 June 2017
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Transformation update. ➢ Child and Adolescent Mental Health Services (CAMHS) update. ➢ Incident management annual report 2016/17. ➢ BDU governance group annual report 2016/17. ➢ NICE guidance annual report 2016/17.

Equality and Inclusion Forum

Date	16 May 2017
Presented by	Ian Black
Key items to raise at Trust Board	➢ BAME staff network update and issues raised around Datix and staff release. ➢ Disability staff network. ➢ Equality Impact Assessments (EIA) should become more mainstream. ➢ Quality Delivery System (EDS2) update. ➢ The Insight Programme. ➢ BAME panel as part of Non-Executive Director recruitment process.

Mental Health Act Committee

Date	16 May 2017
Presented by	Chris Jones
Key items to raise at Trust Board	➢ Mandatory training. ➢ Ethnicity data and inconsistent collection practice. ➢ Inconsistent use of holding powers. ➢ Positive engagement of wards in audit processes.

Nominations Committee

Date	13 June 2017
Presented by	Ian Black
Key items to raise at Trust Board	➢ Non-Executive Director recruitment. ➢ Lead Governor self-nominations.

Remuneration and Terms of Service Committee

Date	23 May 2017
Presented by	Rachel Court
Key items to raise at Trust Board	➢ Human Resources risk register. ➢ Performance Related Pay (PRP) scheme 2016/17. ➢ Redundancy business case. ➢ Directors Pay Award. ➢ Sickness targets. ➢ Agency expenditure.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 22 May 2017

Present:	Dr Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, OD and Estates
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair of the Trust (Chair)
	Dawn Stephenson	Director of Corporate Development
Apologies:	Members	
	Nil	
	Other	
	Ian Black	Chair of the Trust
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Carol Harris	District Director, forensic and specialist services
	Sean Rayner	District Director, Barnsley and Wakefield
	Karen Taylor	District Director, Calderdale and Kirklees
	Rob Webster	Chief Executive
In attendance:	Karen Batty	Assistant Director, Nursing, Clinical Governance and Safety
	Emma Jones	Integrated Governance Manager (author)

CG/17/36 Welcome, introduction and apologies (agenda item 1)

The Chair (JF) welcomed everyone to the meeting and the apologies were noted.

CG/16/37 Consideration and approval of the Quality Account 2016/17 (agenda item 2)

Tim Breedon (TB) introduced the item and commented that due to the prescriptive nature of the requirements a public summary version would also be produced.

Karen Batty (KB) highlighted the feedback provided by the external auditors on the local and mandated indicators:

- Patients on Care programme Approach (CPA) who were followed up in 7 days - two cases had been excluded incorrectly.
- Delayed transfers of Care (DTOC): the percentage of people who were occupying a hospital bed when they were ready to be discharged - two cases were being checking for accuracy.
- Two CQUINS are waiting on results back from the Royal College of Psychiatrists.
- Mental health safety thermometer: monitoring of medication omissions - awaiting results due to a national change of provider.

The Committee reviewed the document and discussed the following amendments:

- Under the “our quality priorities – summary of performance in 2016-17” section the table should be updated to communication the information in a clearer way. This changed for 2016-16 from 7 domains to the 5 Care Quality Commission (CQC) domains.

- Figures under “quality risks – agency spend” section to be checked.
- Suggested wording under the CQC ratings chart “we continue to improve as we aim to be outstanding” be changed to “relevant for today, ready for tomorrow” to link in with a Trust value.
- Any text that references a table below to be moved onto the same page as the table.
- Under section 3 and figures received before 31 May 2017 to be included as well as the RAG rating. If not results grey to be used instead of blue.

The Committee felt the document read and flowed better than last year and that the use of the 5 CQC domains worked well. The Committee thanked the staff involved in the production of the Quality Account.

It was RESOLVED, subject to the above and any minor processing amendments, to APPROVE the final draft of the Quality Account for 2016/17 and to RECOMMEND their approval to the Audit Committee as part of the Annual Report and accounts for 2016/17.

CG/16/38 Date of next meeting (agenda item 3)

The next Committee meeting will be held on Tuesday 13 June 2017 at 9.30am in Meeting Room 1, Block 7, Fieldhead, Wakefield.

NHS
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Minutes of the Mental Health Act Committee Meeting held on 16 May 2017

Present:	Dr. Adrian Berry	Medical Director / Deputy Chief Executive (lead Director)
	Ian Black	Chair of the Trust
	Tim Breedon	Director of Nursing and Quality
	Julie Fox	Deputy Chair of the Trust
	Chris Jones	Non-Executive Director (Chair)
	Dawn Stephenson	Director of Corporate Development
Apologies:	Members	
	Nil	
	Others	
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Lorraine Jeffrey	Independent Associate Hospital Manager
	Gill Pepper	Safeguarding Adults Named Nurse, Barnsley Hospital NHS Foundation Trust – acute trust representative
	Stephen Thomas	MCA/MHA Team Manager (Wakefield)
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Yvonne French	Assistant Director, Legal Services
	Mike Garnham	Health Intelligence Analyst, Service Innovation and Health Intelligence
	Emma Jones	Integrated Governance Manager (author)
	David Longstaff	Independent Associate Hospital Manager
	Dr Piyush Prashar	Consultant Psychiatrist & Clinical Lead-Acute Care (item 2)

MHAC/17/14 Welcome, Introductions and Apologies (agenda item 1)

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

MHAC/17/15 The Act in Practice (agenda item 2)

MHAC/17/15a Acute Service Line – use of the Act in clinical settings (agenda item 2.1)

Presentation from Dr Piyush Prashar on Psychiatric Inpatient Wards.

CJ asked what improvements Dr Prashar would like to see in the service. Dr Prashar advised that he would like to see further improvement through leadership, training and development days.

The Committee thanked Dr Prashar for his presentation.

MHAC/17/16 Legal update/horizon scanning (agenda item 3)

MHAC/17/16a MCA Law Commission report (agenda item 3.1)

Julie Carr (JC) reported that the report and draft Bill were published in March 2017 following a request by Government to review the Deprivation of Liberty Safeguards (DoLS) regime. The proposals include draft legislation and a new system to authorise deprivation of liberty in a care placements for people who lack capacity and are of unsound mind.

The final report and draft Bill recommends that the DoLS be repealed with pressing urgency. The risk to the Trust was RAG rated as amber as no response has yet been provided by the government and progress is likely to be delayed as a consequence of the up-coming general election, however any amendment to the MCA is likely to have significant implications to the Trust.

It was RESOLVED to NOTE the update and SUPPORT the RAG rating.

MHAC/17/16b Policing and Crime Bill – place of Safety 135&136 MHA 1983 (agenda item 3.2)

JC reported that this part of the MHA relates, amongst other things, to police powers under the Act and implications to places of safety. Work had already commenced due to reduction in timescale under section 136. A standard operating procedure (SOP) had been drafted and was with partner agencies for comment. The risk to the Trust was RAG rated as amber. The Trust has been working in collaboration with partner agencies to ensure that policies, procedures and guidance are in place to support implementation. The draft SOP was discussed at the Trust's 136 Place of Safety Group on the 25 April 2017. The date for publication of the Regulations and implementation remains uncertain.

It was RESOLVED to NOTE the update and SUPPORT the RAG rating.

MHAC/17/16c Deprivation of liberty (DoL) on discharge: conditional discharge and CTOs (agenda item 3.3)

JC reported that the Court of Appeal had given judgment in two cases related to conditions being imposed upon conditional discharge or on a community treatment order (CTO) which objectively meant the patient was deprived of his liberty. Previous rulings were clear that you cannot have people discharged on restricted order that would amount to a set of conditions that with amount to a DoL and it was clear that there cannot be a set of conditions under a CTO that would amount to DoL. There had been a slight change with the upholding of the position of restriction orders, however for CTOs there could now be conditions because the RC has the authority and right to detain the patient. JC felt there would be further testing of the judgement. The risk to the Trust had been RAG rated as green as the Trust have very few such cases and has good working relationships with the supervisory bodies to ensure that all such decisions and practices are lawful.

It was RESOLVED to NOTE the update and SUPPORT the RAG rating.

MHAC/17/16d National Mental Capacity Forum: Chair's annual report 2016 (agenda item 3.4)

JC reported that the Forum had completed its first year and next year aimed to move forward with embedding practices. There was potential for the Trust to sign up as members of the Forum to share and access learning from other organisations. The risk to the Trust had been RAG rated as green as the Trust has access to and was utilising the resource.

It was RESOLVED to NOTE the update and SUPPORT the RAG rating.

MHAC/17/17 Minutes of previous meeting held on the 14 March 2017 and 27 March 2017 (agenda item 4)

MHAC/17/17a 14 March 2017 (circulated via email 4 April 2017)

It was RESOLVED to APPROVE the notes of the meeting held on 14 March 2017 as a true and accurate record of the meeting.

MHAC/17/17b 27 March 2017 (attached)

It was RESOLVED to APPROVE the minutes of the meeting held 27 March 2017 which ratified the decisions from 14 March 2017 as a true and accurate record of the meeting.

MHAC/17/18 Matters arising (agenda item 5)

MHAC/17/18a Action points (agenda item 5.1)

The action points were noted and two items raised:

- MHAC/17/05 - Anne Howgate (AH) had provided some information via email that would be included in the action log.
- MHAC/17/11a - Dr Adrian Berry (ABe) advised that he has been clear with the Datix team that any incident relating to clinical care should be reported on Datix.

MHAC/17/19 Annual report – due February 2018 (agenda item 6)

This item is due in February 2018.

MHAC/17/20 CQC compliance actions (agenda item 7)

MHAC/17/20a MHA Code of Practice action plan (agenda item 7.1)

Yvonne French (YF) reported that the Media Devices Policy had been approved by the Executive Management Team (EMT) and the Police Assistance Policy had been reviewed in line with recent NICE Guidance. The policies that remain RAG rated as amber were multiagency policies waiting for approval by partner agencies. Progress had been made around transfer of patients and some issues may be picked up as part of the standard operating procedure.

Dawn Stephenson (DS) advised that the Human Rights Statement had been approved by the EMT.

It was RESOLVED to NOTE the update.

MHAC/17/20b MHA/MCA/DoLs mandatory training update (agenda item 7.2)

YF reported the position as at end of April 2017 for Mental Capacity Act (MCA) training which was applicable to all staff was 69.94% against the target of 80% with work continuing. Mental Health Act (MHA) training of staff working within mental health services was at 51%. Training programmes were place to end of June 2017 with extra training dates added and focus on hot spots. Train the trainer was taking place around the MCA.

Tim Breedon (TB) advised that the status was discussed by the Executive Management Team and Trust Board as part of the Integrated Performance Report. There was a delay with some data being placed onto the system. Training was discussed by the Operational Management Group who acknowledged that it was still a priority area and there were issues within releasing staff to attend the training. There was a commitment that training levels would reach the required targets by end of Quarter.

The Committee acknowledged the work being done in this area but expressed its concern about the lack of progress. The Committee challenged the amber RAG rating but accepted the justification offered around training session in place and commitment to release staff to attend the training.

It was RESOLVED to NOTE the update and SUPPORT the RAG rating.

MHAC/17/21 Audit and Compliance Reports (agenda item 8)

MHAC/17/21a Consent to treatment audit (agenda item 8.1)

JC reported that the audit took place in March 2017 across 11 mental health inpatient wards and highlighted the following:

- A green RAG rating was achieved for the correct certificate of authorisation being in use showing significant improvement over the past 12 months.
- An amber RAG rating was achieved for the recording of an assessment of capacity to consent to the proposed treatment as required by 25.17 of the code of practice. There was evidence of an assessment of capacity to consent to the proposed treatment, found in 81% of clinical records subject to this audit.
- A Green RAG rating at 95% (was maintained for the holding of the certificate of authorisation with the medicine card.
- Work was taking place to continue to improve these rates.

ABe commented that the audit was a targeted programme to ensure a high response rate and provide more meaningful data. This would now be rotated over different wards.

It was RESOLVED that the overall RAG rating should be green and SUPPORT the recommendations within the paper:

- **to ensure the Committee have assurance of compliance with the consent to treatment requirements of Part 4 MHA and chapters 24 and 25 of the code of practice the consent to treatment should remain on the Committees annual work programme.**
- **that all wards should be reminded that any new certificates of authorisation received by the ward must be forwarded to the local MHAO in a timely manner. This will be monitored through the local MHA/Ward meetings.**
- **Doctors have been reminded through the March JAPS of the requirement for the recording of assessments of capacity to support certificates of authorisation. Compliance with this requirement will be monitored through the local MHA/Ward meetings.**
- **that a future audit of the quality of the recording of capacity be undertaken to seek assurance of compliance with the requirements of 24.32, 24.37 & 24.45-24.47 of the code of practice once a green RAG rating for the recording of capacity assessment to support the certificate of authorisation is achieved.**

MHAC/17/21b Section 17 leave cancellation audit (agenda item 8.2)

JC reported that the main theme identified in the audit for service users not taking authorised escorted leave was due to the approval of unescorted leave accompanied by an approved relative or friend. Within forensic services staffing issues were raised as a reason. This matter has been raised with the governance practice coach and assurance provided that work was ongoing to address the matter with an action plan to be provided to the Committee. TB advised that forensic services had not operated with unsafe staff levels at any time and the issue raised related to staff not being able to be deployed to support escorted leave at particular times. There has been significant improvement over the last 12 months, therefore the risk to the Trust had been RAG rated as amber.

It was RESOLVED to NOTE the update and SUPPORT the recommendations within the paper:

- **for the Trustwide single day access to escorted leave audit to remain on the Committees annual work programme to enable the Committee to monitor access to s.17 leave against the requirements of MHA Code of Practice 27.3 & 27.27.**

- **for a Trustwide simple compliance audit regarding the completion of the new s.17 leave forms that have been introduced with the revised Trust s.17 leave policy. The purpose of this recommendation is to provide the Committee with assurance of compliance with MHA Code of practice 27.22 & 27.23.**
- **that Forensic services continue to monitor cancellation of leave. It is recommended that a review of escorted s.17 leave due to shift cover issues be conducted by the Forensic BDU with the findings and any action plan being reported to the Committee.**

MHAC/17/21c Ethnicity recording (agenda item 8.3)
Dawn Stephenson (DS) reported that in relation to concerns around the recording of ethnicity a simple audit would be conducted.

JF asked if service users refused to disclose whether it was recorded in the clinical record and reiterate that it does not mean that they could not be asked again in future. MG commented that leaflets had been developed on how to ask people for the information in the right way.

It was RESOLVED to NOTE the work undertaken to date and the actions to be taken.

MHAC/17/22 Care Quality Commission visits (agenda item 9)

MHAC/17/22a Recent visits summary report (agenda item 9.1)
The three monitoring visits to Ashdale (18 January 2017), Ryburn (12 December 2016) and Priory (17 January 2017) were noted.

JC commented that the monitoring reports and submitted action plans were becoming more detailed. The Committee requested that future reports be reports by exception.

Action: Julie Carr

It was RESOLVED to NOTE the update.

MHAC/17/22b Outstanding actions/progress report (agenda item 9.2)
YF reported that there had been good progress on the actions and a system was in place for oversight by practice governance coaches and BDU directors. In relation to the outstanding forensic services item a timetable would be put in place over a two year period.

The Committee discussed the trust-wide action in relation to how service users are able to communicate with family and friends whilst in forensic services with access to the internet part of a number of action plans. DS advised that the Executive Management Team (EMT) agreed for internet access to be provided within forensic services which will be evaluated and reported back to the EMT including the difference that it has made to service users. JF asked if the Trust charged service users for phone calls within Forensic servicers.

Action: Tim Breedon

It was RESOLVED to NOTE the update.

MHAC/17/23 Monitoring Information (agenda item 10)

MHAC/17/23a Monitoring information Trustwide January–March 2017 (agenda item 10.1)
Mike Garnham (MG) reported that positive feedback and response had been received from BDUs. Work was continuing to improve information flows and accuracy of data. A deep dive around non-attendance had not shown any evidence of a change of practice or service delivery as a cause. There had also been a decline in the number appeals against detention.

JC commented that in relation to the repeated uses of sections 5(2) and 5(4) further work was taking place to review the criteria and detail. In relation to the length of wait, it had been recently agreed with CQC to review it on a regular basis.

It was RESOLVED to ENDORSE the recommendations within the paper:

- **to request that the BDU's review the ethnicity reporting and recording processes.**
- **to support a review of the frequency and appropriateness of urgent authorisations under the DoLS.**
- **to support an on-going review of the disproportionate use of s.5(2) in the Kirklees and Calderdale BDU review the increase in admissions and admissions under the mental health act for service users from a Black/Black British background.**

MHAC/17/23b Local Authority information (agenda item 10.2)
Shirley Atkinson (SA) reported that there were delays in assessments in community getting them in appropriate beds in hospitals and felt there was a decrease in requests for assessments in the last quarter. A new method for recording has been set which should provide a more accurate understanding.

It was RESOLVED to NOTE the update.

MHAC/17/23c Hospital Managers' Forum Notes 7 April 2017 (agenda item 10.3)
David Longstaff (DL) reported that the Forum discussed changes to IR35 rules with a further update to the Forum at the end of May 2017 and the annual pay uplift of 1% in line with the NHS pay aware. The trialling of e-expenses was progressing well.

It was RESOLVED to NOTE the update.

MHAC/17/23d Compliments/complaints/concerns in relation to the Mental Health Act, January–March 2017 (agenda item 10.4)
JC reported that one complaint was received in the last quarter which was addressed fully.

It was RESOLVED to NOTE the update.

MHAC/17/23e Hospital Managers concerns – January–March 2017 (agenda item 10.5)
JC reported that one response remains outstanding. Compliments highlighted the quality of reports and care provided by clinical teams.

It was RESOLVED to NOTE the update.

MHAC/17/24 Partner agency update (agenda item 11)

MHAC/17/24a Local Authority (agenda item 11.1)
Discussed under agenda item 10.2 Local authority information.

MHAC/17/24b Acute Health Care (agenda item 11.2)
This item was not taken.

MHAC/17/25 Key Messages to Trust Board (agenda item 12)

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

- Mandatory training.
- Ethnicity data and inconsistent collection practice.
- Inconsistent use of holding powers.
- Positive engagement of wards in audit processes.

MHAC/17/26 Date of next meeting (agenda item 13)

The next Committee meeting will be held on 1 August 2017 in Meeting Room 1, Block 7, Fieldhead from 2.00-4.30pm.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 June 2017
Agenda item 9

Title:	**Use of Trust seal**
Paper prepared by:	Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used two (2) times since the report to Trust Board in March 2017 in respect of the following: ➢ Contract for the sale and purchase of Castleford and Normanton and District Hospital, Lumley Street, Castleford between the Trust and Persimmon Homes Limited. ➢ Contract for the sale of freehold land with vacant possession at South Kirkby Health Centre, Bransley Road, South Kirkby, Pontefract between the Trust and Calderwood Property Developments Limited.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in March 2017.**
Private session:	Not applicable.

NHS
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Trust Board annual work programme 2017-18

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Standing items								
Declaration of interest	✘	✘	✘	✘	✘	✘	✘	✘
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Assurance framework and risk register	✘		✘		✘		✘	
Customer services quarterly report	✘		✘		✘		✘	
Guardian of safe work hours	✘		✘		✘		✘	
Investment appraisal framework	✘		✘		✘		✘	
Serious incidents quarterly report		✘		✘		✘		✘
Use of Trust Seal		✘		✘		✘		✘
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework	✘				✘			
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Annual items								
Draft Annual Governance Statement (final approval by Audit Committee)	✘							
Audit Committee annual report	✘							
Compliance with NHS Improvement/Monitor licence (date to be confirmed by NHS Improvement)	✘							
Planned visits annual report	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Annual report, accounts and quality accounts update on submission		✘						
Customer services annual report		✘						

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Health and safety annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Code of Governance compliance				✘				
Sustainability annual report				✘				
Assessment against NHS Constitution					✘			
Operational plan						✘		
Trust Board annual work programme						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Information Governance toolkit								✘
Strategic objectives								✘
Policies and strategies								
Membership Strategy *(next due for review in April 2019)*	✘							
Quality Improvement Strategy *(next due for review in July 2017)*			✘					
Constitution (including standing orders), Scheme of Delegation and Standing Financial Instructions *(next due for review in January 2019 or as required)*								
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(next due for review in January 2019)*								
Risk Management Strategy *(next due for review in January 2019)*								
Treasury Management Policy *(next due for review in January 2019)*								
Information Management and Technology Strategy *(next due for review in April 2019)*								
Communication, Engagement and Involvement strategy *(next due for review in December 2019)*								
Organisational Development Strategy *(next due for review in December 2019)*								
Workforce Strategy *(next due for review in March 2020)*								

	Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)
	Performance and monitoring
Strategic sessions are held in February, May, and November which are not meetings held in public.	
There is no meeting scheduled in August.	
# Corporate Trustees for the Charitable Funds which are not meetings held in public.	