With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual Report and Accounts

for the period 1 April 2014 to 31 March 2015

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE PERIOD 1 APRIL 2014 TO 31 MARCH 2015

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

Message from the Chair and Chief Executive

Welcome to the Trust's annual report for the year 1 April 2014 to 31 March 2015.

This has been another challenging and demanding year not only for this Trust but for the NHS as a whole and the challenges for our Trust have demonstrated how important it is for us to continue to work in partnership with people who use our services, our staff, our stakeholders and the local communities we serve.

Whereas 2013/14 was, in many senses a year of discussion with the Trust undertaking a critical look at its position and where it wanted to be, this year has been one of turning these discussions into reality through the transformation of our services and a real emphasis on delivering our vision. In terms of delivery, this means making the necessary changes to services to build a successful future, aligned to the transformation work led by commissioning bodies to ensure the Trust continues to play a key role within local and regional partnerships and the wider health and social care economy.

It is not good enough just to make changes to our services; what is important is how these changes are made, which is why working to our values is so crucial. During a time of development and challenge, our values are even more important to us linking back to what service users tell us about their care and staff tell us about their working lives. Living our values encourages each and every one of us to demonstrate and celebrate the Trust's values in the care we provide.

Over the past year, we have again maintained a strong financial position, working hard to meet the requirements of our independent regular, Monitor, and also, from a quality perspective, meeting the compliance requirements of the Care Quality Commission. Throughout the year, we sought to maintain this compliance by remaining true to our values, in particular, remaining open, honest and transparent in all our dealings and embracing the Duty of Candour, which continues to be very much embedded in our values.

As Chair and Chief Executive, throughout the year, we continued to meet with a whole range of staff and witness first-hand the excellent work they do in challenging circumstances. The drive, passion and commitment we see in all parts of the Trust is heartening. The NHS has been subject to much criticism during the year and what often goes unreported is the fantastic work people do on a day-to-day basis and the real difference this makes to people's lives. What we achieve is based on the loyalty, hard work and endeavour of our staff, working in partnership with service users.

This challenging and demanding year has a number of highlights of which we can and are justifiably proud.

- Creative Minds, our innovative initiative that uses creative approaches and activities in healthcare, won the Health Service Journal Award for Compassionate Patient Care. The Award was sponsored by the Department of Health and was presented by the Rt. Hon. Jeremy Hunt, Secretary of State for Health. The judges said that Creative Minds took user-led services to a different level, hailing "the empowerment of service users that demonstrates personal and economic benefits for individuals, families and whole communities." This award reflects years of hard work, skill and commitment by many of our staff and our service users.
- The involvement and engagement of our service users, staff, local communities and governors in adopting a radical approach to our services and determining how they can be fit for the future, as well as having relevance to the present has informed our vision for

our services. We do now, of course, face a significant challenge to deliver this transformation and the commitments we have made to people who use our services.

- Our service visits programme undertaken across the Trust by Directors, staff and service users has gone from strength to strength and offers opportunities for services to learn from each other and to spread good practice. This last year, we awarded outstanding ratings to three of our services. For Trust Board, this is our best opportunity to see day-to-day care in action and talk to service users and carers about the real level of care we offer every single day.
- Our Chief Executive was recognised in the Queen's Birthday honours list in 2014 gaining an OBE for services to healthcare. This is a fantastic achievement for Steven individually and for the Trust as an organisation. It preceded his recognition as one of the Top 50 provider Chief Executives in the NHS. Steven sees this as a recognition to be shared by every one of our staff.

Finally, on a personal note, as Chair the work I enjoy most is the recognition events we run for our staff to reflect their achievements. All our staff strive to offer the best they can to service users, but these events reflect real excellence and achievement. The ones that epitomise what we are trying to achieve as a Trust are the achievements of staff who set out on their career journey at the same time as I did and are of a similar generation. They have the best stories to tell about the history of the NHS and it is humbling to hear them.

Given the challenges we face, remaining as we are is not an option. In terms of delivery, this means making the necessary changes to services to build a successful future. Looking ahead, we face significant challenges but we have a strong platform to work from, built on a track record of achievement, putting service users at the heart of everything we do. We do not always get this right but we must learn from the times we do not. We remain confident that we have a strong future and that we will continue to enable people to reach their potential and live well in their community.

Thank you for taking the time to read this report; we hope you find it interesting and informative.

Ian Black
Chair
22 May 2015

Steven Michael
Chief Executive
22 May 2015

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Introduction

We are a specialist NHS Foundation Trust providing community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide some medium secure (forensic) services across Yorkshire and the Humber.

The Trust was established in April 2002. The period since has seen great change, growth and achievement. In May 2009, we became an NHS Foundation Trust. Foundation trusts are still part of the NHS and operate according to NHS principles – free care, based on need, not ability to pay – but they are run locally and are accountable to their members.

In April 2011, we moved from being a specialist mental health and learning disability provider to an integrated and partnership-based provider of community and mental health services. This followed the transfer of a range of community services to the Trust in Barnsley, Calderdale and Wakefield.

Over 1 million people live in Barnsley, Calderdale, Kirklees and Wakefield across urban and rural communities from a range of diverse backgrounds. We aim to match our communities' needs with locally sensitive and efficient services. We work with other local NHS organisations to provide comprehensive health care to people in our area. We also work closely with local authorities (social care) and with other government departments and voluntary organisations. Working in partnership is very important to us and is vital if we are to continue delivering high quality services for local people.

Working in partnership also means working with the members of our Trust, who have a say in how we run the Trust and how they wish our services to be developed. Around 16,500 local people (including our staff) are currently members.

The Trust now employs around 4,800 staff and, to provide the flexible, individually tailored care that local people have told us they want, we provide services from over 50 main sites. The majority (98%) of the care we provide is in the local community, working with people in their own homes or in community-based locations. Our community-based services are supported by in-patient services for people who need care or assessment in a hospital setting.

Our Mission, Vision, Values and Goals

Our mission is to enable people to reach their potential and live well in their community. We do this by:

- doing the day job well, delivering our quality and financial targets;
- delivering the service transformation programme; and
- managing our partnerships.

Our values underpin our mission and support us to create the common sense of purpose, uniting our services and our staff. They guide us each day to ensure we provide the best possible care for local people and underpin the approach of our staff in providing this care. Our values reflect the openness and transparency of the organisation, clearly and succinctly.

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

Section 1 – Strategic Report

Our business model

Our business model is built on our values and on the partnerships we foster and develop with our service users and carers, our staff, our stakeholders and our wider partners. It is founded on the principles of developing and delivering person-centred approaches to our services tailored to individual need, providing greater control for individuals with an emphasis on recovery and positive outcomes for services users. This includes developing and delivering improved quality at reduced cost, providing care closer to home based on innovative models of service provision, which use research-based best practice as their basis leading to safe, effective and efficient services.

Partnership is essential to our mission and vision. We operate across five local clinical commissioning groups and four local authority areas, as well as regionally across Yorkshire and the Humber for our forensic services. Our main service areas reflect the NHS single definition of quality, that care should be effective and safe, and provide as positive an experience as possible. Nationally, parity of esteem (where mental health and physical health care are seen as equal) for people with mental health needs is recognised as a priority. This and the need to work with people in a holistic recovery-focused way are central to the way we deliver and develop services. Growing demand for early diagnosis of dementia and provision of compassionate care and support for people with dementia and their families is a major driver for our services, as is the need to ensure dignity for all, including at the end of life.

Locally, we support commissioner's quality priorities through quality, innovation, productivity and prevention schemes. We also work with our commissioners to agree commissioning for quality and innovation incentives, developing locally meaningful targets to support commissioning priorities relevant to our services.

Specifically, the Trust's business model focuses on its chosen plan for sustainability predicated on The Trust's chosen plan for sustainability:

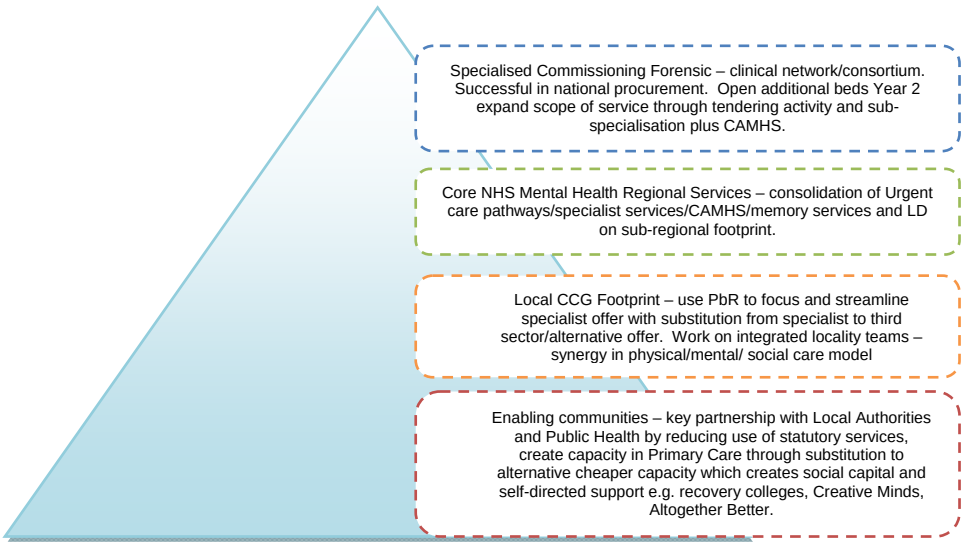
- driving hard on its cost improvement programme through transformation in years one to three of its five-year plan; and
- increasing our focus on income generation through specific plans at service level.

In addition, the five-year plan recognised that the challenges of sustainability for the services we provide will become increasingly challenged from year three onwards; therefore, the emphasis for the Trust is additionally on:

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

Our Board identified a four-step model (see below) to support the Trust through the next challenging phase. This model articulates how the Trust's business model will support its sustainability by driving the re-shaping of the Trust's cost base through efficiencies in workforce, service models and infrastructure in 2014/15 and 2015/16, and creating substitution activity for statutory services in 2016/17 at lower cost using a recovery model and building on the success of Creative Minds and alternative capacity models. From 2016/17 onwards, the Trust predicts that sustainability can only be achieved through

development of core NHS services on larger geographic footprints, such as, West Yorkshire or Yorkshire and the Humber for specialist services to reduce support service costs whilst maintaining local, responsive delivery of community services, which have greater reliance on self-directed support and self-care.



Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust, and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary. Its attitude to risk is prudent and pragmatic, adopting a flexible approach to risk and determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and will determine its approach and its appetite for risk to suit the circumstances at the time.

The Trust's workforce is by our most important resource. Our staff make the biggest difference to the lives of the people who use our services and it is their dedication, commitment and professionalism that means we can deliver services that enable people to reach their potential and live well in their community. Our aim, therefore, is to develop a value-based culture that makes our staff feel able and capable to deliver the best quality services possible within the resources available. This requires investment to ensure we recruit, retain, develop and motivate a representative workforce that has the right skills to continue to provide responsive, effective and safe mental health, learning disability and community services.

The make-up of our Board and staff at 31 March 2015 is outlined below.

	Total	Male	Female
Non-Executive Directors	6	4 (67%)	2 (33%)
Executive Directors	5	4 (80%)	1 (20%)
Other Directors	5	1 (20%)	4 (80%)
Staff	4,740	1,082 (23%)	3,658 (77%)

Our strategic approach and objectives

Our operational plan for 2014/15 set out the significant level of service and financial challenge facing the Trust over the next two years. The plan was intended to enable the Trust to:

- sustain a performance culture, which delivers positive patient experience and continuous service improvement;
- continue to generate efficiencies and savings to maintain services;
- implement significant changes to our workforce in terms of roles, skill mix and numbers as a key enabler for the re-design of our services; and
- navigate the expected changes in service delivery and the flow of funds driven by system-wide integration and transformation schemes, and national initiatives, such as the Better Care Fund and Pioneer Status in Barnsley.

In support of this challenge, our strategic objectives, agreed by our Board to provide the organisational focus to support our strategic direction and to provide clarity on where we need to concentrate our efforts to remain a successful and sustainable organisation, were identified as to:

- develop integrated models of care with acute, community, third sector and local authority partners;
- define the organisational form required to deliver sustainable services, including exploration of new strategic partnerships to create and utilise alternative capacity; and
- broaden our clinical networks, specifically forensic services.

These were supported by a set of overarching service priorities to:

- integrate urgent care pathway to foster and facilitate whole system efficiency;
- achieve significant improvement in outcomes for long-term conditions with a holistic approach to mental and physical healthcare and social factors to provide parity of esteem for mental health;
- provide a focus on health and wellbeing, promoting self-care and prevention;
- put people in control of their own care through a recovery approach, self-care and improved use of technology;
- work in partnership to support healthy communities and to build and grow alternative capacity through innovative approaches to the delivery of our services; and
- achieve critical mass through the provision of specialist services.

Our approach over the last year has, therefore, been to:

- continue the focus on organisational development making 2014 our ‘Year of Values’ drawing on the work previously undertaken to support staff in providing a good service;
- focus on delivery by driving efficiencies using benchmarking against our quality priorities to identify opportunities to improve the effectiveness and efficiency of our services, and further development of service line management to fully understand the cost of our services and the contribution they make;
- focus on service re-design to support the delivery of significant efficiencies in 2015/16 through our transformation programme, which is aligned to commissioner intentions through the inclusion of the programme workstreams in our contracts with commissioners;
- maintain a level of surplus and EBITDA greater than 1% and 5% respectively;

- maintain a strong cash position to support our capital programme to develop community hubs and re-develop our Fieldhead site in Wakefield;
- deliver a significantly increased cost improvement programme of £12.9 million (5.7%), which enabled us to also manage cost pressures of around £4 million;
- be prudent in our downside scenario planning for those areas likely to be tested competitively, such as secure services, psychological therapies and community services for dementia and long-term conditions.

Our achievements

A number of key areas for delivery were identified in our plan for 2014/15.

1. Revision of our service offer the transformation programme for mental health, learning disabilities, secure services and general community services.
2. Review of workforce efficiency through for, for example, the introduction of twelve-hour shifts in in-patient wards, reviewing medical staff remuneration and productivity, and management of vacancies.
3. Development of new workforce models to enable more people to access self-directed support and reduce crisis interventions and the need for admission. This recovery-based model is a critical element in our transformation programme and was also reflected in the Joint Strategic Needs Assessment and commissioning strategies of our clinical commissioning groups and local authorities.
4. Implementation of a leadership development programme, which supports managers and staff at all levels to equip them with the skills and resilience to implement significant service and cultural change.
5. Implementation of different ways of working, for example, the use of technology and estate to support more efficient deployment of staff, agile working and expansion of telehealth services, and better sharing of information and communication with service users by the development of web-based portals and information sharing agreements with other providers.
6. Review of management structures and skills and a focus on service line reporting to ensure managers have the right capacity, skills and tools to manage resources effectively.
7. Continue to play a key role in developing business cases and implementation of major service change at system level working in partnership with local providers and commissioners.

Our achievement is summarised below.

Strategic goal	2014/15 summary
Focus on recovery and self-care	• The Trust's recovery college approach has been implemented across all four districts and provides a platform to build on for the benefit of local people and people who use our services. • Creative Minds continues to grow and develop. Since its launch in November 2011, Creative Minds has delivered more than 150 creative projects in partnership with over 50 community organisations. This has benefited over 4,000 people. In 2014, it won a national award (Health Service Journal award for compassionate patient care) and its brand recognition continues to grow. • The Trust's delivery of health and wellbeing services has seen growth but resourcing this delivery in the current funding climate presents a challenge.
Deliver transformation and cost savings	• Transformation schemes continue to progress towards the 'delivery' phase, particularly in learning disability and

Strategic goal	2014/15 summary
	forensic services, and some areas of mental health and general community services. There are some exceptions, which will provide a focus for the coming year. • The cost improvement programme requirement was met, although there were areas met non-recurrently and through substitutions from the original plan.
Effective and efficient support services	• This was not a major focus in 2014/15 and will be developed in the year ahead • Investment has been made in agile working, business development and project management. A partnership team has also been established to re-focus the Trust's approach to our engagement activity, particularly with people who use our services, to facilitate development of our vision for volunteering and to provide more focused approach to diversity and inclusion.
Partnership and income generation	• There has been limited progress with the development of regional networks for specialised commissioning although there has been good progress with national positioning. • Strong progress has been made towards the end of the year for a sub-regional core for mental health provision. • Partnerships with local partners on 'locality models' are relatively strong. • There has been continued progress with developing and maintaining relationships and partnerships with the third sector, notably Creative Minds, the recovery approach and Altogether Better.

In 2014/15, the challenges to achieving our cost improvement programme whilst maintaining the quality and standard of service to our service users were managed through the Quality Impact Assessment, led by the Director of Nursing and Medical Director, which has enabled robust challenge to the impact on our services of efficiency, productivity and cost savings and forms a key part of the transformation agenda to ensure that what we do does not affect the quality of the services we provide. We continue to ensure that our services remain patient-centred and that the outcomes from the Quality Impact Assessment are monitored routinely at the highest level of the organisation, aligned with performance reports, service user and carer feedback and feedback from commissioners.

Focus on delivery of our cost improvement programme in a challenging year was supported by the establishment by the Chief Executive of a weekly operational requirement group to enable the Trust to achieve its target of £12.9 million. This group will continue into 2015/16.

Quality review and our achievements

Our commitment and approach to quality is at the very heart of what we do. Our Quality Accounts provide a review of our performance over the year as well as setting out our priorities for the year ahead.

Our approach to quality is set out in our Quality Improvement Strategy, which uses the definition of 'Quality' as set out in the Darzi Report, High Quality Care for All (2008), with its three main elements of patient safety, clinical effectiveness and patient experience. The purpose of the Strategy is to ensure that we capture the essence of quality and translate this effectively by bringing together national policy, strategic direction and regulatory, financial and governance requirements with our stated imperative of providing safe, effective care for every person who accesses our services. Our Quality Improvement Strategy outlines our commitment and approach to quality and shows that quality is at the heart of what we do.

The Trust adopted a Quality Improvement Framework in 2013/14 based on the work of the National Quality Board. It is made up of seven domains and is used by the Trust and our Board to provide assurance on and reporting against the quality of our services.

1. **Bringing Clarity to Quality** – There must be a clear and accepted definition of quality that is understood and owned by people who use services and their carers, staff and commissioners. Assurance is derived from service offer documents, InPac definitions and outcome development.
2. **Measuring Quality** – Robust timely and relevant information must be available at all levels of the delivery system in order to demonstrate improvement. Assurance is derived from service line and BDU reporting, and the performance dashboard.
3. **Publishing Quality** – By publishing accessible information about quality performance, we increase accountability and empower people. Examples include the 'What Matters' report, the Members' Council performance report and the Trust's Excellence Awards.
4. **Partnerships for Quality** – The Trust works with others to support people. Examples include integrated community mental health teams, Spectrum partnerships and the Change Lab.
5. **Leadership for Quality** – Leadership is required at all levels to ensure focus on quality and appropriate system incentives. There is a specific role for clinical, managerial and professional leadership. Examples include professional leadership networks and managerial/clinical partnerships as our approach to service line management.
6. **Innovation for Quality** – continuous improvement requires the Trust to be alert and to seek out opportunities for innovation. This is demonstrated by our approach to developing alternative capacity to provide support for service users and their carers through such initiatives as Creative Minds and Altogether Better.
7. **Safeguarding Quality** – It is vital that the Trust ensures essential standards of safety and quality are maintained. Embedding quality in the delivery system will ensure that this happens and is monitored through robust performance reporting, unannounced visits to services, the 15-Steps challenge and the quality priority monitoring regime.

Our Quality Improvement Strategy is supported by a Quality Improvement action plan, developed from national and local intelligence and includes workstreams to support achievement of our quality priorities, strategic actions to support the Trust's response to its external environment, actions from patient, carer and public engagement and experience feedback, CQUIN schemes agreed with commissioners, the Monitor Risk Assessment Framework and quality improvement areas identified through clinical audit, incident analysis, external and internal inspections and visits. Monitoring of the Quality Improvement Action Plan is undertaken by the Clinical Governance and Clinical Safety Committee.

Our Quality Improvement Strategy is underpinned by seven quality priorities, which have taken a consistent approach over the past three years. Against each priority, we set measures of success. These measures have been developed through wide consultation with staff, people who use our services, our Trust's Members' Council and partners. The measures are reviewed and refreshed each year to ensure we adapt to local and national intelligence, making sure we progress against our aim to "improve and be outstanding".

Priority 1: Service users are central to what we do (Listen and act). We want people who use our services to have a positive experience. We strive to listen and act on patient feedback to continually to improve this experience.

Priority 2: Timely access to services (Access). We want to improve access times for people who are referred into our services so they get the right support from the right service at the right time.

Priority 3: Improve care (care, care planning and evaluation). We believe that individualised personal care is essential to enable a person's recovery. Everybody should have an appropriate assessment of their needs and an individualised care plan that supports them in achieving their goals.

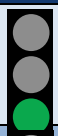
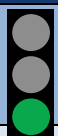
Priority 4: Improve record keeping and data quality (recording care). We want to record each intervention in a timely manner. This is vital in providing safe, effective clinical care.

Priority 5: Improve transfers of care by working in partnership across the care pathway (Care pathways). We want to support service users to move along the care pathway in a timely way. We also want services to communicate effectively to prevent duplication or gaps in service provision.

Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake their duties (Fit and well to care). We know that our staff are our most valuable asset. We are committed to valuing our workforce and know that staff who feel valued are more likely to provide excellent care.

Priority 7: Improve the safety of our service users, carers, staff and visitors (Safety). We have a duty of care to our service users, carers, staff and visitors to protect them from harm. We want to deliver safe, effective and appropriate treatment, as well as safe buildings in which to work and receive care.

Our quality priorities – summary of performance in 2014/15

Quality priority	Progress	Quality priority	Progress
Listen and act		**Care pathways**	
Access		**Fit and well to care**	
Care planning		**Safety**	
Recording care		Key: Green: 75% or more of KPIs achieved Amber: 65-74% of KPIs achieved Red: Less than 65% of KPIs achieved	

Quality developments

- We met our external quality requirements and continue to be registered with the Care Quality Commission.

- One of the outcomes of the Francis Report was the introduction of reporting by all Trusts on safer staffing levels. We undertook internal and external benchmarking and made a commitment to invest over £1 million in safer staffing, particularly for in-patient services. This included £216,000 investment in Newton Lodge, £662,000 investment in crisis services in Calderdale and £200,000 to establish a peripatetic nursing team to enable the Trust to respond to operational hotspots with trained and qualified staff. This also links to our ambition to reduce reliance on agency staff and associated cost supported by the implementation of a neutral vendor. The investment also supports the Trust's move to increase workforce efficiency through such initiatives as agile working and to support revised workforce models, such as the introduction of twelve-hour shifts across in-patient areas. Continued deployment of this investment will continue in 2015/16.

- Building on the Quality Improvement Strategy developed last year, we have developed a Patient Safety Strategy, in consultation with service users and carers, staff and stakeholders, to improve the safety culture within the organisation and enhance the effectiveness and positive experience of the service we provide.

- We have also signed up to the national 'Sign up to Safety' campaign, are active in local Patient Safety Collaboratives, have made a commitment to the Crisis Care Concordat with partners with a robust action plan in place, and are working with commissioners to achieve a substantial reduction in in-patient care for people with learning disabilities.

- We evaluated our position in relation to new statutory duties overseen by the Care Quality Commission in relation to Duty of Candour and the Fit and Proper Person requirement for our Board and staff, and made preparations for change to Care Quality Commission inspection regime.

- We implemented values-based induction, recruitment and appraisal processes. During the year and introduced a new organisational leadership and management framework to promote a strong local governance focus in all services.

- Our complaints procedures have been improved in line with the recommendations from the Patient Association Review, leading to stronger learning loops. In addition, as part of our implementation of the Friends and Family Test, we have developed patient experience dashboards which support real time feedback for staff and service users.

- During 2014/15, we have improved our seclusion facilities and made a number of practice improvements following an inspection visit to the Fieldhead site in 2013/14 when two compliance actions were issued to the Trust. We anticipate that the Care Quality Commission will review these improvements during 2015.

Quality Risks

To maintain rigour around our progress, we put in place challenging performance indicators against each priority. We have maintained a good standard of performance against the majority of the indicators; however, there are some areas where there has been consistent underperformance against targets in 2014/15.

Access

- Underachievement against the 90% target for face-to-face contact within 14 days of referral for people with non-acute mental health problems in Calderdale, Kirklees and Wakefield.
- Underachievement against the 100% target of Barnsley CAMHS patients seen within 5 weeks of referral

Improve care and care planning

- Underachievement against the 90% target regarding adherence to cluster reviews in mental health

Improve recording and evaluation of care

- Concerns remain with the quality of clinical record keeping and data quality.

Staff professionally, physically and mentally fit to do their duties

- Underachievement against the 4% sickness target (however the Trust remains compliant with the national 5% target)
- Underachievement of internal goals for staff friends and family test

For each quality improvement area, there is a clear organisational leadership processes so we can monitor and review them. A quality group has been set up with cross-organisational multi-professional quality leader representation. The group will be responsible for implementation and ongoing monitoring of the quality improvement action plan.

We will continue to use our annual clinical audit programme to make sure improvements are implemented and sustained. Sustainability is also supported by a programme of reporting to Trust Board regarding quality performance, compliance with CQC regulatory requirements, compliance with the terms of our foundation trust licence and assessment against national and local targets including CQUINs.

Our focus on transformation activity may lead to a lack of attention to quality within the day-to-day delivery of services and we will manage this risk through regular monitoring and reporting against quality indicators to EMT and Trust Board and clear accountabilities for both operational delivery and transformational change.

The Trust continues to operate a robust quality impact assessment process that is applied to all cost improvement programme changes before implementation. This rigorous challenge process helps safeguard quality and includes review at several organisational levels.

Our quality improvement initiatives for 2015/16 are organised under the headings of our seven quality priorities, which have been consistent over the past three years. We consulted with stakeholders, through the Quality Account Survey, to inform our quality priorities for the coming year. This information, along with patient experience feedback, our Commissioning for Quality Improvement Scheme (2015/16) and our annual governance report information has determined our priorities for 2015/16. Against each of our quality priorities, we set ourselves measures of success. The measures are reviewed and refreshed each year to make sure we're adapting to both local and national intelligence, and progressing against our aim to '***improve and be outstanding'***.

Quality governance arrangements

The Trust has robust quality governance arrangements in place and our approach to quality reinforces the commitment to quality care that is safe, person-centred, efficient and effective. Our approach specifies the responsibilities held by individuals, business delivery units, the Executive Management Team and Trust Board, co-ordinated by the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance. Trust Board and the Executive Management Team receive quarterly quality performance reports as well as monthly compliance reporting against quality indicators. We monitor performance against Care Quality Commission regulations through a quarterly self-assessment. External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of areas of Trust services, Care Quality Commission Mental Health Act visits, achievement of level 1 NHS litigation authority risk management standards NHSLARMS status, and implementation of Essence of Care and Productive Ward). Measures are implemented and maintained to ensure practice and

services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.

The Trust continues to build on its existing service user insight framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. This has resulted in an increase in the number of issues raised and in the number of compliments received, which is a positive development in the context of the encouragement that the Trust gives to people to offer feedback in all its forms.

There are no material inconsistencies between the Annual Governance Statement, annual and quarterly Board statements required by Monitor's Risk Assessment Framework and reports arising from the Care Quality Commission.

Our achievements – operational

Our performance against Monitor's governance and financial risk ratings during 2014/15 has been good with the Trust remaining green in all four quarters reflecting our anticipated position set out in the annual plan.

	Annual plan 2014/15	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Continuity of service rating	Green	Green	Green	Green	Green
Governance rating	Green	Green	Green	Green	Green

	Annual plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial risk rating	Green	Green	Green		
Governance risk rating	Green	Green	Green		
Under the Risk Assessment Framework					
Continuity of service rating				Green	Green
Governance rating				Green	Green

There were no formal interventions in 2014/15.

Performance review and analysis of key performance indicators

Trust Board identified a number of key performance indicators for 2014/15 relating to key areas of Trust activity. The following is a summary of the position at 31 March 2015.

Business Strategic Performance – impact and delivery			
	KPI	**Target**	**Month 12 position**
CQC	CQC quality regulations (compliance breach)	Green	Green
CQUIN	CQUIN Barnsley	Green	Amber/Green
	CQUIN Calderdale	Green	Amber/Green
	CQUIN Kirklees	Green	Amber/Green
	CQUIN Wakefield	Green	Amber/Green
	CQUIN Forensic	Green	Amber/Green
IAPT	IAPT Kirklees % who 'moved to recovery'	52%	53%
Infection prevention	Infection prevention (MRSA and C Diff cases)	8	2
C-Diff	C-Diff preventable cases	0	0

Business Strategic Performance – impact and delivery			
	KPI	**Target**	**Month 12 position**
PSA outcomes	% service users on CPA in employment	10%	7.3%
	% of service users in settled accommodation	60%	69%

Customer focus			
	KPI	**Target**	**Month 12 position**
Complaints	% complaints with staff attitude as an issue	<25%	18% 29/159
FOI	% of requests for information under the act processed in 20 working days	100%	100%
Media	% of positive media coverage relating to the Trust and its services	>60%	92%
Members' Council	% of publicly elected governors actively engaged in Trust activity	>50%	50%
	% of quorate council meetings	100%	100%
Membership	% of population served recruited as members of the Trust	1%	1%
	% of 'active' members engaged in Trust initiatives	>50%	40%
Befriending services	% of service users allocated befriender within 16 weeks	>70%	64%
	% of service users requesting a befriender assessed within 20 working days	>80%	100%
	% of potential volunteer befriender applications processed within in 20 working days	>90%	100%

Operational effectiveness: process effectiveness			
	KPI	**Target**	**Month 12 position**
Inpatients/ community	Delayed transfers of care (DToC) (Monitor)	< = 7.5%	4%
	% admissions gatekept by Crisis teams (Monitor)	95%	99%
	% SU on CPA followed up within 7 days of a discharge (Monitor)	95%	97%
	% SU on CPA having formal review within 12 months (Monitor)	95%	98%
	Meeting commitment to serve new psychosis cases by early intervention teams	95%	178%
Data quality	Data completeness: community services (Monitor)	50%	100%
	Data completeness: identifiers (mental health) (Monitor)	97%	100%
	Data completeness: outcomes for patients on CPA (Monitor)	50%	82%
Mental health PbR	% of eligible cases assigned a cluster	100%	95%
	% of eligible cases assigned a cluster within the previous 12 months	100%	76%
	% inpatients (all discharged clients) with valid diagnosis code	99%	99%

Fit for the future: workforce			
	KPI	**Target**	**Month 12 position**
Appraisal	Appraisal rate Band 6 and above	95%	96%
	Appraisal rate Band 5 and below	95%	97%
Sickness	Sickness absence rate (YTD)	4%	4.8%
Vacancy	Vacancy rate	10%	5.5%
Safeguarding	Adult safeguarding training	80%	82%
Fire	Fire attendance	80%	86%
Info Governance	Information Governance training	95%	96%

- We achieved 91% of our Commissioning for Quality and Innovation (CQUIN) targets. This represented a monetary figure of £4.1 million.
- During 2014/15, we improved the use of service line reporting to support more granular service line level planning, which led to a review of areas such as improving access to psychological therapies, health and wellbeing and substance misuse services.
- The infrastructure for operational delivery was enhanced by the establishment of arrangements at service line level to provide a framework where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to continue to improved Trust services and achieve transformation. The 'trios' provide strengthened leadership and management arrangements, stronger business partnering between support and operational services, health intelligence and innovation, and business planning processes at service line level.

- The establishment of 'trios' is beginning to see positive results, driving up quality and performance within BDUs. The 'trio' arrangements are still at an early stage of development and will remain a key area of focus for the year ahead.
- There has been a focus on mandatory training and further staff development aligned to new roles and models of care. One development has been the introduction of a risk-based approach to mandatory training to ensure its application and take-up is focussed and prioritised,
- The Trust continues to work with its commissioners to determine local issues in order to develop and improve performance and quality.

Transformation

Our strategic approach in 2014/15 continued with our ambitious plan for the transformation of our services in mental health, general community, forensic and learning disability services across all our districts. This reflects the need to make some radical changes to the way we deliver services. We continued to engage and consult with our service users, carers, staff, partners and stakeholders and to base our vision for services on ensuring that:

- we provide services that keep service users at the centre and which focus on people's potential;
- if people choose to make use of technology, we need to make it available;
- all organisations, both big and small, should work together so that the joins cannot be seen;
- people recognise early on if someone is having problems so that we can provide help and support;
- we offer as much choice as possible and help people to understand those choices; and
- we support families and carers.

Building on these themes and based on our values and priorities, clinicians and support staff working together have created high level visions for our services. These include:

- care closer to home;
- supporting people to live independently in their own homes rather than living in institutional settings in the Trust or in private sector placements;
- improved outcomes for people with long-term conditions, both in mental health and general community services;
- supporting people to be more in control through the use of technology;
- establishing recovery colleges, which offer more creative approaches to recovery through education, confidence-building and participation;
- increased emphasis on self-directed support, self-care and prevention of ill-health;
- building alternative capacity through links to social networks, community groups and peer support; and
- use of lean principles across all services, improved community locations and increased agile working.

During 2014/15, we moved all our transformation projects from the initiation ('discovery') phase into the 'design' phase and a number of projects then successfully moved from 'design' to implementation and delivery during the second half of the year:

- acute and community mental health services;
- learning disability services;
- rehabilitation and recovery services; and
- long-term conditions.

The remaining projects will see tangible plans for delivery in the first three months of 2015/16 and we will also further develop new transformation opportunities whilst supporting the transition of existing projects into operational delivery and benefits realisation to achieve 25% of the value of our cost improvement programme for 2015/16 which comes from the transformation of our services.

One particular area of concern during the year has been child and adolescent mental health services (CAMHS) in Calderdale and Kirklees. The transfer of these services in 2013 has not been without risk to the Trust and a robust action plan is in place to ensure we can continue to deliver the service safely and to address concerns to lay the foundation for a programme of service transformation to improve and develop the service. We have taken a number of actions during the year to strengthen leadership and management arrangements, particularly at senior level with the appointment of an interim District Service Director for the service and the appointment of a cross-Trust clinical lead for the service. We have also provided dedicated support, particularly around information management and technology, and HR, undertaken engagement and listening events for staff, led and facilitated by the Chief Executive, and improved engagement with families who use the services with the result that the clinical recovery team is starting to receive positive feedback, and met with commissioners to come to an agreed health economy-wide solution to the current issues. Additional resources were invested by both commissioners and the Trust to stabilise the position, address the backlog of referrals and ensure that administrative process were in place to support the clinical service. A total of £800,000 has been expended over and above the original contract value, of which commissioners contributed £347,000 and the Trust the remainder. This has supported enhanced staffing levels to deal with the demands of the service.

Our achievements – financial

The Trust had an annual turnover of £237.7 million for 2014/15 and an overall surplus of £3.1 million (1.3%) for the year. This compared to a planned surplus of £2.6 million. Of its total income, 83% was generated by healthcare contracts with NHS England and local health commissioners (Clinical Commissioning Groups (CCGs) in Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield) and 10% was received for services provided under contracts with from local authorities . The majority of contract income was commissioned as a fixed payment; however, 2.5% (£4.5 million for 2014/15) was based on the achievement of key quality indicators. The Trust achieved £4.1 million (91%).

The Trust met its requirements set out in its annual plan for 2014/15.

The financial performance is scored by the regulator Monitor using the Continuity of Service Risk Rating. The score in the annual plan was 4; the score achieved was 4. The maximum score achievable is 4.

The Trust achieved a savings target of £12.9 million during the year, delivering the plan in full. This position was achieved with £10.1 million (78%) delivered as set out in the original programme and £2.8 million (22%) through mitigations and substitutions. Each proposal was subjected to a Quality Impact Assessment, led by the Director of Nursing and Medical Director, enabling robust challenge to the impact on services of efficiency, productivity and cost savings and to ensure services remain patient-centred.

The capital budget was revised in year from the initial £11.8 million to £8.1 million. The actual expenditure was £6.1 million which is a £2 million (24%) variance compared to the revised plan. The slippage was due to external planning and development delays, and re-prioritisation of investment. The capital programme did, however, deliver a number of notable schemes. The Fieldhead infrastructure scheme was completed providing a renewal

of water ring mains and mains electrical cables, which included inbuilt resilience for future projects alongside completion of improvements to inpatient facilities on the Fieldhead site within medium secure services. This year has also seen the commencement of significant capital investment in the Trust's estate with the development of community hubs in Calderdale and Barnsley. These hubs form a key element of the Trust's Estates Strategy and enable savings to be realised whilst delivering a higher standard of accommodation.

The Trust planned and maintained a healthy cash balance throughout the year with a balance of £32.6 million as at 31 March 2015. This is £5.75 million ahead of plan and is predominately due to the delays in capital spending. During 2014/15, as this trend emerged, the Trust used this additional flexibility to tactically bring forward some investment in information management and technology, vital to the continued provision of sustainable services.

External strategic risks

At the start of the year, we identified a number of external risks and challenges facing the Trust.

1. **We identified**
   The level and pace of change required to our workforce both internally and externally would impact negatively on team performance and potentially service quality.
   We are acting
   This was mitigated through investment in organisational development and leadership, practical schemes to support staff wellbeing and proactive engagement of staff representatives. The Trust developed and introduced new leadership and management arrangements to ensure that District Service Directors were able to focus on providing the strategic partnership contact for business delivery units (BDUs) ensuring effective links with all partner and stakeholder agencies and to ensure effective delivery of the Trust's plan within each BDU. This was facilitated by the appointment of deputy directors to carry operational responsibility to support District Service Directors in the delivery of services within BDUs and to manage the 'trio' relationship in support of effective delivery. Within BDUs, 'trio' arrangements were established. This working relationship ensures general managers, clinical leads and practice governance coaches work collectively to ensure excellence in service quality and delivery with clinical leads ensuring effective clinical engagement and prioritisation, general managers responsible for ensuring appropriate deployment of resources and practice governance coaches ensuring best practice is followed and effective clinical governance is maintained and developed.

2. **We identified**
   The commissioning intentions of clinical commissioning groups, local authorities and specialist commissioners are not fully aligned with the Trust vision of the future for services, increasing the risk of de-commissioning, which could undermine services and the financial viability of the Trust.
   We are acting
   This was mitigated by maintaining positive working relationships with commissioners and ensuring the Trust was proactively involved in system transformation projects across our footprint. The plan identified three particular areas of concern, which the Trust effectively mitigated during the year. The Trust was involved in the implementation of the Better Care Fund in all areas and facilitated the understanding of commissioners of mental health currency and how its continued development will support transformation.
   The need for the Trust to develop a credible bid for the national procurement for secure services did not materialise in-year although the development work undertaken by the

Trust during the year and the continued work to establish a provider network will hold the Trust in good stead for the anticipated procurement exercise in 2015/16.

3. **We identified**
   The political and financial imperatives in local health and social care economies mean that some organisational re-configuration is likely and, therefore, the current organisational form will not be sustainable over the life of the Trust's five-year plan.
   We are acting
   The preparation and planning for this risk continues to be reviewed and considered by our Board.
4. **We identified**
   There is a risk that managing the transition to new structures will impact negatively on the services and outcomes achieved for service users.
   We are acting
   This was and continues to be mitigated by ensuring the Trust is actively involved in influencing the future shape of health and social care economies across the geographical footprint.

Our Charitable Funds

The Trust is a Corporate Trustee for its own charitable funds and is governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. Its charitable funds include the Creative Minds funds and the Mental Health Museum-linked charity. Its objective is to promote the effective administration and management of the Trust's Charitable Funds, ensuring that access to those funds meets the expectation of the original donors. The Trustee's actions are guided by a commitment to ensure:

- funds are accessible for the purpose for which they were donated;
- accurate documentation of donor wishes;
- compliance with Charities Commission guidance; and
- accountability for all monies received or expended.

Further information can be found in the Charitable Funds Annual Report for the year ended 31 March 2014, the latest year for which information is available, on the Trust's website at Charitable Funds annual report 2013/14. The annual report for 2014/15 will be produced later in the year.

The Charitable Funds Committee, formed in 2003, manages the Charity on behalf of the Corporate Trustee, chaired by a Non-Executive Director of the Trust. The day-to-day operations of the Charitable Funds are administered by the Trust.

Looking ahead

The Trust's plan for 2015/16 sets out a deficit financial position of £0.7 million. This provides for ongoing investment in services, unavoidable cost pressures, and non-recurrent investment in information management and technology to support agile working as part of the transformation agenda whilst continuing to realise a cost improvement programme and manage the downward pressures arising from tariff deflation and commissioning decisions. The underlying financial trend provides a recurrent surplus of £3.5 million and maintains an overall continuity of service risk rating of 4.

For 2015/16, the Trust's major strategic initiatives will focus on:

- our transformation programme;

- our service strategy to ensure a Trust-wide approach for all key service lines is developed to provide the best services we can to users of our services supported by a workforce strategy that supports our quality priority to ensure staff are fit and well to care;
- closer relationships with GP federations in our local health economy;
- active partnership in local Vanguard projects;
- developing a compelling vision and plan for the development of the basis of a multi-speciality community provider;
- preparing for the national procurement exercise for medium and low secure services;
- delivering of Tier 4 child and adolescent mental health services in partnership with the Priory Group;
- health and wellbeing services by consolidating existing services and making the transition to a scalable model of service;
- transition to a scalable model of service for attention deficit hyperactivity disorder and autistic spectrum disorder and focused marketing of the Trust's services;
- development of scalable support services through transformation and in partnership with others.

Strategic goal	2015/16 action
Focus on recovery and self-care	• Strengthen operational links with primary care, the third sector and local authorities to support resilient communities • Implement innovative service models for integrated 'whole person' physical and mental health with primary care • Expand and extend the application of the award winning Creative Minds brand and our leading edge work on co-production through recovery colleges
Deliver transformation and cost savings	• Implement acute and community pathway and explore opportunities for transformation of acute mental health with partners on a wider footprint • Re-visit our service offers and operational models to optimise quality, consistency and efficiency in response to our quality surveillance work and feedback from stakeholders. This is specifically relevant to mental health liaison services, ward-based mental health rehabilitation, child and adolescent mental health services, ADHD and improving access to psychological therapies. • Drive the operational implementation of the current tranche of transformation projects and apply the understanding derived from our health intelligence, marketing and quality improvement work to scope and commence the next tranche of transformational change in both service provision and support services. This will be used to drive the Trust's cost improvement programme..
Effective and efficient support services	• Fully mobilise use of digital technology, changing how we communicate and use information • Drive delivery of the capital programme for estates investment in support of quality and transformation • Engage our workforce to harness creativity and energy for transformation supported by investment in leadership and management development through clinical microsystems
Partnership and income generation	• Partnering and positioning for forensic procurement • Development of proactive commercial marketing and relationship management approaches in line with the Dalton Review • Partnering in all localities for sustainable services through initiative such as Vanguard and the Prime Minister's

Strategic goal	2015/16 action
	Challenge Fund, with particular emphasis on primary care relationships and integrated mental and physical healthcare • Prepare for the possibility of major transactions leading to the development of the organisational structures that best support our strategic intent

Ian Black
Chair
22 May 2015

Steven Michael
Chief Executive
22 May 2015

It should be noted that the Trust has prepared consolidated accounts and the strategic report, therefore, relates to the undertakings included in the consolidation; however, greater emphasis is given in the report to the Trust's activities. There is a full annual report and accounts produced for the Trust's charitable funds.

Section 2 – Directors' report

This section of the annual report supports the strategic report setting out our governance arrangements and how these have operated over the last year. The framework for the arrangements is set out in the Trust's Constitution, which is supported by the Trust's standing orders, standing financial instructions and scheme of delegation.

The Scheme of Delegation describes those powers and matters reserved for Trust Board. These are generally those where the Trust remains accountable to the Secretary of State and to its regulators, Monitor and the Care Quality Commission. It also describes the delegation of the detailed application of Trust policies and procedures to the appropriate level. Trust Board remains accountable for its functions, including those delegated to the Chair, the Chief Executive, individual directors or officers, and has in place arrangements to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The Directors' report has been prepared in accordance with the relevant Sections of the Companies Act 2006 and appropriate regulations, as well as making the additional disclosures required by Monitor in its Financial Reporting Manual and other disclosures as appropriate. Information on research and development, the Trust's approach to the employment of disabled persons and providing employees with information on matters of concern to them, consultation with employees and involvement of employees in the performance of the Trust, and the financial risk management objectives and policies are included in the following report.

The Directors of the Trust consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.

Our Board

Our Board is responsible for setting the strategic direction and associated priorities for the organisation to enable it to deliver appropriate, high quality, safe, effective and efficient services to our service users, their carers and stakeholders whilst remaining effective, sustainable and viable. The Board ensures effective governance for all services and provides a focal point for public accountability. It also has overall responsibility for probity (standards of public behaviour) within the Trust and is accountable for monitoring the performance of the organisation against its strategic direction, and ensuring corrective action is taken where necessary.

The composition of the Board is in accordance with the Trust's Constitution, providing a structure to enable it to fulfil its statutory duties and functions, and to ensure the Trust continues to meet the conditions of its Licence. All Non-Executive Directors are considered to be independent.

The Chair is responsible for ensuring the Board focuses on the strategic development of the Trust and for ensuring robust governance and accountability arrangements are in place. The Chair also chairs the Trust's Members' Council meetings, ensuring there is effective communication between the Trust Board and the Members' Council, and that the views of the Members' Council are sought and listened to.

The Chair and Non-Executive Directors are appointed by the Members' Council following a recruitment and selection process managed on its behalf by the Nominations Committee. The Nominations Committee makes recommendations on the appointment or re-

appointment of the Chair and Non-Executive Directors to the Members' Council. The Members' Council also has the ability to remove Non-Executive Directors and the Chair from post.

Trust Board has a variety of individual skills and experience, which they bring to bear on the work of the Trust. Each director's experience is described below, along with any declaration of interest as at the end of March 2015.

The Trust considers that the balance and membership of Trust Board is appropriate and has the balance of skills, experience and knowledge it needs to act as an effective unitary board of a Foundation Trust. It regularly reviews the balance, completeness and appropriateness of the Board to meet such requirements. Where appropriate, the Trust will look to recruit and/or retain individuals with certain skills and experience to ensure that this is maintained. The Trust involves its Members' Council in this process through the Nominations Committee.

The make-up of Trust Board at 31 March 2015 is as follows.

	Total	**Male**	**Female**
Non-Executive Directors	6	4 (67%)	2 (33%)
Executive Directors	5	4 (80%)	1 (20%)
Other Directors	5	1 (20%)	4 (80%)

No Executive Director serves as a Non-Executive Director in another NHS Trust or NHS Foundation Trust.

Individual performance of members of Trust Board is assessed as follows.

- The Deputy Chair/Senior Independent Director, with support from the Board and the Members' Council, has a process in place to appraise the Chair annually. The outcome of this appraisal is reported to the Members' Council. For 2014/15, the outcome was very positive with the Chair is seen as balanced, focussed, professional, approachable, and operating with integrity, setting a tone for the Trust, which is confident and on the front foot. His promoting of the Trust's achievements is much appreciated, particularly by governors. Ensuring the right things are discussed at Trust Board, and managing positive relationships with the Members' Council and with the Chief Executive are seen as particular strengths.
- The Chair of the Trust undertakes bi-annual reviews with Non-Executive Directors.
- The Chair of the Trust undertakes quarterly reviews with the Chief Executive.
- The Chair and the Chief Executive have undertaken 'pairs coaching' with an external facilitator, aimed at enhancing the working relationship between them.
- The Chief Executive undertakes quarterly reviews of performance against objectives with Executive Directors and his Executive Management Team.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Non-Executive Directors			
Chair **Ian Black** Appointed as designate 20 March 2008 Substantive from 1 May 2008 to 30 April 2012 Deputy Chair from 1 June 2010 to 31 January 2012 Acting Chair 1 February 2012 to 30 April 2012 Chair 1 May 2012 to 30 April 2015 Re- appointed 1 May 2015 to 30 April 2018		➢ Non-Executive Director, Benenden Healthcare (mutual) ➢ Non-Executive Director, Seedrs (with small shareholding) ➢ Private shareholding in Lloyds Banking Group PLC (retired member of staff) ➢ Chair, Family Fund (UK charity) ➢ Chair, Keegan and Pennykidd (insurance brokers) ➢ Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management ➢ Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire	➢ Chartered Accountant and management consultant. ➢ 20 years at Halifax plc/HBOS with a series of director roles in finance, IT, operations, risk and customer service in the UK, Europe and Australia. ➢ Particular areas of experience are financial management, risk and funding/investment ➢ Chair, Family Fund UK ➢ Variety of charitable interests nationally and locally. ➢ Non-Executive Director, Benenden Insurance ➢ Chair, Keegan and Pennykid Insurance Brokers ➢ Non-Executive Director, Seedrs (FCA authorised internet investment) ➢ Formerly School Governor for six years. ➢ Formerly pension fund trustee ➢ Formerly Governor, Beaumont FE College, Lancaster ➢ Formerly Treasurer (and ex-chair) of Scope (UK disability charity). ➢ Formerly Non-Executive Director Nisa-Today's plc
Non-Executive Director (Chair of Audit Committee to 1 January 2015) **Peter Aspinall** Appointed as designate 1 November 2008 for an initial period of 12 months. Appointed by Members' Council from 1 May 2009 to 30 April 2012 Re-appointed from 1 May 2012 to 30 April 2015		No interests declared	➢ Over 20 years of Board and Leadership Team experience. ➢ Finance Director in a number of significant manufacturing and commercial organisations including complex multinational environments. ➢ Membership of integration and change management experience gained resultant to significant merger.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Non-Executive Directors			
Non-Executive Director (Chair of Audit Committee from 1 January 2015) **Laurence Campbell** Appointed 1 June 2014		➢ Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council	➢ 20 years' experience as Finance Director of large corporate businesses including two Public Limited companies, all with significant international operations. ➢ Very interested in the development and implementation of strategy, and the balance between risk and opportunity.
Non-Executive Director **Julie Fox** Appointed 1 August 2011 to 31 July 2014 Re-appointed 1 August 2014 to 31 July 2017		No interests declared; however, currently on secondment to the Youth Justice Board; however, this is not likely to conflict with the non-executive director role	➢ Leadership, management and partnership in criminal justice ➢ Senior manager in residential offender services and contract management, for example, accommodation, education, training and employment ➢ Positive diversity achievements both strategic and operational ➢ Previously in probation and youth justice inspection (working closely with other inspectorates such as HM Inspectorate of Constabulary, HMI Prisons and the Care Quality Commission) ➢ Currently working for the Youth Justice Board in quality improvement ➢ HR experience in recruitment and staff development ➢ Four years restaurant ownership

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Non-Executive Directors			
Non-Executive Director **Jonathan Jones** Appointed 1 June 2010 to 31 May 2013 Re-appointed 1 June 2013 to 31 May 2016		➢ Member, Squire Patton Boggs (UK) LLP ➢ Member, Squire Patton Boggs (MENA) LLP ➢ Spouse, Company Secretary, Zenith Leasedrive Holdings Limited and its subsidiaries ➢ Spouse, shareholder, Zenith Leasedrive Holdings Limited	➢ Member of Squire Patton Boggs, a major international law firm. ➢ Specialises in corporate finance law (with particular experience in private equity). ➢ Clients come from a variety of sectors including healthcare. ➢ Issues confronting the legal profession at present include estates, people and technology and he has applied his experience of those to his involvement in the Trust.
Deputy Chair/Senior Independent Director **Helen Wollaston** 1 August 2009 to 31 July 2012 Re-appointed from 1 August 2012 to 31 July 2015 Interim Deputy Chair/Senior Independent Director 1 February 2012 to 30 April 2012. Interim period extended from 1 May 2012 to 31 July 2012 Deputy Chair/Senior Independent Director 1 August 2012 to 31 July 2015		➢ Director, Equal to the Occasion Ltd. (consultancy) ➢ Director, WISE, a (Women in Science and Engineering), a social enterprise promoting women in science, technology and engineering	➢ Over 20 years' experience in the public and voluntary sectors, including executive and non-executive roles. ➢ Founder/Director Equal to the Occasion, a consultancy to support equality and diversity projects. ➢ 7 years as Director of Campaigns at Equal Opportunities Commission. ➢ 3 years as Regional Manager of National Lottery Charities Board in Yorkshire and the Humber. ➢ Strong track record in working with marginalised communities. ➢ Contacts in science and technology sector through current role as Director of the WISE campaign.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Executive Directors			
Chief Executive **Steven Michael** Appointed 1 April 2002 Acting Chief Executive from 4 September 2006 Chief Executive from 12 February 2007 (Secondment to DoH 1 October 2010 to 31 January 2011)		➢ Member of Huddersfield University Business School Advisory Board ➢ Member, Leeds University Centre for Innovation in Health Management ➢ Member, Leeds University Centre for Innovation in Health Management International Fellowship Scheme ➢ Partner, NHS Interim Management and Support ➢ Trustee, Spectrum People ➢ NHS Confederation elected Chief Executive representative, Mental Health Network Board ➢ Health and Wellbeing Boards, Wakefield and Barnsley ➢ Involvement in Care Quality Commission mental health inspection arrangements	➢ Occupied role of Accountable/Accounting Officer from February 2007 leading the Trust to Foundation Trust status in May 2009. ➢ Three decades experience of working in the NHS with Executive Director experience since 2000. Recognised by HSJ as being in the top 50 Provider Chief Executives nationally 2015. ➢ Significant clinical leadership experience both as nurse leader and clinical director at key points in career. ➢ Experience in working in not for profit sector at senior management level. ➢ Partnership working, in 2014. ➢ Recognised by HSJ and Local Government Chronicle as being the sixth most influential leader in the country for Health and Social Care Integration. ➢ Track record in project management including large and complex capital projects. ➢ Strong record in contract and planning negotiation with commissioners. ➢ Experience in working at both regional and national level including secondment in 2010/11 as Regional Director of Provider Development for Yorkshire and the Humber and project work for the Department of Health. ➢ Long history of effective engagement with service users and carers. ➢ Strong commitment to value based organisational development and the role creativity plays in supporting this. ➢ Record in working with a range of universities including Newcastle-upon-Tyne, Northumbria, Huddersfield and Leeds.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Executive Directors			
Medical Director **Adrian Berry** Appointed 1 November 2010 Appointed as Medical Director 1 October 2014		No interests declared	➢ 16 years' experience of clinical care as consultant forensic psychiatrist and of training specialist registrars ➢ Leader of clinical management team 1999-2003 ➢ Associate medical director and Trust Board member 2003-2005 ➢ Program director for specialist forensic training in Yorkshire and Humber 2006-2009 ➢ Clinical project lead for a number of capital projects and service developments ➢ Contract management and negotiation experience with specialist commissioning team
Director of Nursing, Clinical Governance and Safety **Tim Breedon** Appointed District Director for Wakefield 1 November 2010 Acting Director of Nursing from 16 July 2012 Director of Nursing from 17 December 2012		No interests declared	➢ Over 25 years' experience in the health and social care market with both public and private sector experience. ➢ Executive Director experience in both public and private sector environments, including Managing Director of a Long Term Health Care PLC. ➢ Significant senior management experience in both local authority and charitable sector at key points in career. ➢ Five years' experience as a self-employed management and training consultant. ➢ Director level responsibility for PLC acquisition and merger plan. ➢ Significant experience in contract negotiation and delivery on contracts, including the delivery of capital investment programme to support growth. ➢ Lead professional adviser on learning disability policy, strategy and commissioning for both PCT and local authority. ➢ Well documented history of partnership working, including the chairing of multi-agency partnership boards. ➢ Nurse leadership roles in a variety of care and support settings

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Executive Directors			
Director of Human Resources and Workforce Development **Alan Davis** Appointed 1 April 2002		No interests declared	➢ 33 years' experience of HR in the NHS ➢ 19 years as an Executive Director of Trust ➢ Human Resource Management ➢ Leadership and Workforce Development ➢ Business Planning ➢ Staff Side/Staff Engagement/Consultation ➢ Chair Childcare Information Service Ltd 10 years (charity providing services to local authorities) ➢ Employee Relations ➢ Investor in People ➢ Member of the Director team leading FT application for SWYPFT and major acquisition ➢ 2009 runner up in NHS HR Director of the Year: nominated by Chief Executive and Staff Side Organisations
Deputy Chief Executive/Director of Finance **Alex Farrell** Appointed 7 September 2009 (Acting Chief Executive 1 October 2010 to 31 January 2011)		➢ Spouse is General Practitioner partner, City View Practice, Leeds	➢ Qualified medical doctor ➢ Retrained in private sector as Chartered Accountant ➢ Re-joined NHS in acute sector and has worked in acute trust, health authority, PCG and PCTs in senior management ➢ 10 years' experience as a Director of Finance. Portfolio experience in strategic financial planning and management; contract negotiation and healthcare tenders; developing Estates Strategy and capital business cases; developing IM&T Strategy and implementation of performance framework based on balanced scorecard; implementation of Integrated Governance and Change Management. ➢ Brings a drive for continual improvement, integrated working and change management linked to good understanding of commissioning, business development, performance management and governance to support the development of the Foundation Trust.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Company Secretary			
Director of Corporate Development (Company Secretary) (non-voting) **Dawn Stephenson** Secondment 8 February 2010 Substantive appointment from 1 April 2011		➢ Voluntary Trustee for Kirklees Active Leisure	➢ Over 20 years' experience at Board level as an NHS Director. ➢ Knowledge of community, primary care and acute through previous experience as Director of Finance, Contracting and Information and Chief Executive in an integrated trust and primary care trust. ➢ Experience in strategic financial management, contracting and IM&T strategy. ➢ Experience in Board governance and risk management. ➢ Experience in public involvement, communications and partnership working. ➢ Experience in acquisitions.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Other Directors			
Interim District Service Director – child and adolescent mental health and forensic services (non-voting) **Nette Carder** Interim appointment 5 January 2015		➢ Director, Athena Leadership and Management Limited	➢ Offers significant experience of leading and transforming Mental Health and Community services, often in troubled environments and frequently working across health and social care to deliver services. ➢ Brings a 'can do' approach, which, coupled with her experience and credibility, enables her to quickly establish good relationships with staff and stakeholders, establish common purpose and drive change and performance improvement. ➢ Over 25 years' Director-level experience.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Other Directors			
District Service Director – Barnsley and Wakefield (non-voting) **Sean Rayner** Transitional post as District Director, Barnsley from 22 February 2011 Substantive from 1 April 2012		➢ Member, Independent Monitoring Board for HMP Wealstun ➢ Trustee, Barnsley Premier Leisure	➢ 25 years' experience in the NHS, with 12 years' experience as an Executive Director. ➢ Barnsley Transition Director in support of Trust acquisition process. ➢ Experience in leadership, business planning, and contract management in multi-agency environments. ➢ Partnership working over 20 years, including chairing and leading service user/carer Partnership Boards. ➢ Experience in project management, including capital projects and LIFT as a premises procurement vehicle. ➢ Experience in GP engagement and accountable officer in a Primary Care Group. ➢ Experience of working in a voluntary capacity in not for profit sector, and a member of HMP Wealstun Independent Monitoring Board (IMB).
Director of Health Intelligence and Innovation (non-voting) **Diane Smith** Interim appointment 9 January 2014 Substantive appointment 1 January 2015		No interests declared	➢ Qualified Biomedical Scientist with an early career in research in academia ➢ Moved into NHS management in Public Health in 1991, working in a District Health Authority as an Epidemiologist and in Senior Management at Regional level in both the NHS and Civil Service. ➢ Progressed into NHS senior leadership as the Chief Executive of a PCG, followed by Director posts in a Strategic Health Authority, ambulance trust and PCT and latterly senior management in NHS England. ➢ Portfolio experience in implementing transformational change; developing organisations; business planning and organisational development; project and programme management; health research methods and analysis; assurance and risk management and working in partnership.

Role/name/appointment		Declaration of interests (as at 31.03.15)	Experience
Other Directors			
District Service Director – Calderdale, Kirklees and Specialist Services (non-voting) **Karen Taylor** Interim appointment 9 January 2012 Substantive from 1 April 2012		No interests declared	➢ In excess of 30 years NHS experience in clinical and managerial roles. ➢ Director level positions held since 2007. ➢ Experience of establishing and managing partnership arrangements with the local authority and third sector organisations. ➢ Strong operational management background up to Director level.

The following member of Trust Board left office during 2014/15.

Name/role/appointment	Experience
Non-Executive Director **Bernard Fee** Appointed as designate 20 March 2008 Substantive from 26 May 2008 to 26 May 2011 Re-appointed 27 May 2011 to 26 May 2014	➢ 30 years management experience with Marks and Spencer. ➢ Strong commercial background across a number of functional areas including finance and operations roles in buying and selling. ➢ Significant marketing experience in both research and delivery. ➢ Strong leadership and development background. ➢ Leading large teams at different levels through strong, focused performance management. ➢ Driving results through people and encouraging individuals to maximise potential.
Medical Director **Nisreen Booya** Appointed 29 January 2004 Retired 30 September 2014	➢ Clinical experience as Consultant Psychiatrist since 1985 in both WAA and OPS ➢ Senior Clinical Lecturer, Leeds University since 1997 ➢ Experience in medical education, training, assessment and appraisal with 17 years' experience as a college tutor ➢ Royal College of Psychiatrists examiner since 1998 ➢ Experience in Clinical Governance including national level as Clinical Governance investigator and reviewer for the CHI and Health Care Commission Associate and CQC Specialist Advisor 2014 ➢ GMC Associate 1997-2013 and GMC – MPTS Panellist since 2013 ➢ Honorary President to Support to Recovery ➢ Secondary care doctor on the Bassetlaw CCG ➢ Experience in service planning, development and innovative service models (won national award Doctor of the Year for Dementia Service 2001) ➢ Contributed to the development of Integrated care Pathways and Package which underpins the PbR in mental health

Attendance at Board meetings 2014/15

Name	29/04	20/05	24/06	22/07	23/09	21/10	16/12	27/01	03/03	31/03	Total
BLACK, Ian	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
ASPINALL, Peter	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
CAMPBELL, Laurence			✓	✓	✓	×	×	✓	×	✓	5/8
FEE, Bernard	✓	✓									2/2
FOX, Julie	✓	✓	×	✓	×	✓	✓	✓	✓	✓	8/10
JONES, Jonathan	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	9/10
WOLLASTON, Helen	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	9/10
MICHAEL, Steven	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
BERRY, Adrian *	✓		✓	✓	✓	✓	✓	✓	✓	✓	9/9
BOOYA, Nisreen	✓	✓	✓	✓	✓						5/5
BREEDON, Tim	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
DAVIS, Alan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
FARRELL, Alex	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
STEPHENSON, Dawn	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
CARDER, Nette								✓			N/A
RAYNER, Sean *	✓			✓		✓		✓			N/A
SMITH, Diane	×			×	✓	✓	✓	✓			N/A
TAYLOR, Karen *	✓			×		×		✓			N/A

* NB from March 2012, only voting Directors and the Director of Corporate Development, in her role as Company Secretary, attend all Trust Board meetings. District Service Directors attend board meetings quarterly.

Our Board Committees

Trust Board discharges its responsibilities through a number of Committees. Trust Board has established four risk committees. The membership and work of the Audit, Clinical Governance and Clinical Safety, and Mental Health Act Committees re outlined below and the Remuneration and Terms of Service Committee in the Remuneration Report.

The Director of Corporate Development attends all Committee meetings, with the exception of the Remuneration and Terms of Service Committee, as part of her role as Company Secretary. The Chair of the Trust and the Chair of the Audit Committee attend at least one meeting of each Committee per year as part of the review of the effectiveness of Non-Executive Directors individually and of Committees. The Audit Committee reviews the effectiveness and integration of Trust Board Committees on an annual basis and presents the outcome of this review in its annual report to Trust Board. This was presented to Trust Board in April 2015. The Committee provided assurance that Committees are effective and integrated and that risk is effectively managed and mitigated through the assurance that:

- Committees meet the requirements of their Terms of Reference;
- Committee workplans are aligned to the risks and objectives of the organisation, which are within the scope of their remit; and
- Committees can demonstrate added value to the organisation.

Information on the Remuneration and Terms of Service Committee is contained in the remuneration report.

Audit Committee

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

Members during 2014/15

Peter Aspinall, Non-Executive Director (Chair to 1 January 2015 and then a member)	Attended five out of five meetings
Laurence Campbell (from 1 June 2014 and Chair from 1 January 2015)	Attended three out of three meetings
Bernard Fee, Non-Executive Director (to 26 May 2014)	Attended two out of two meetings
Jonathan Jones, Non-Executive Director	Attended four out of five meetings

The Audit Committee produces an annual report each year, which provides assurance to Trust Board that it has fulfilled its roles and responsibilities under its terms of reference. The following is an outline of how the Committee has done this in 2014/15.

Internal Audit

The Committee shall ensure that there is an effective internal audit function, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board as follows.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	During 2015, the contracts for both internal and external audit come to an end (KPMG (internal) 30 June 2015 and Deloitte (external) 30 September 2015). The Audit Committee considered the position at its meeting in October 2014 and was of the view that the Trust should not tender for both internal and external audit services at the same time. The Committee agreed, therefore, an extension to the contract for KPMG as the Trust's internal auditors for one year (to 30 June 2016).
Review and approval of the Internal Audit strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	A draft Internal Audit Annual Plan for 2014/15 was presented to and agreed by the Audit Committee in April 2014. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by KPMG. Regular meetings are held with the Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. To January 2015, 15 internal audit reports were presented to the Committee. Of these, there were: - no full assurance opinions; - eight substantial/significant assurance opinions; - six moderate assurance opinions; - one limited/partial assurance reports (patients' property); and - no 'no' assurance opinion. The audit of financial management, which provided a substantial assurance opinion, included a review/follow up of the recommendations from the procurement (non-pay purchasing) audit, which provided a no assurance opinion in October 2013. The follow up found that there had been timely and effective progress in relation to the actions agreed with the Trust, the interim arrangements where permanent solutions have not yet been implemented were effective and there was no indication of breaches in control. As part of this work, KPMG also evaluated the risk of financial loss for the period when control weaknesses were identified and found that there was no indication of financial loss. Management action has been agreed for all recommendations, these are reported to the Committee and, where appropriate, progressed by KPMG. In the main, there are no significant outstanding actions; however, the Committee has

	Progress
	an ongoing concern regarding data quality within the Trust and it has also asked the Executive Management Team to review the findings of the patients' property audit to ensure ownership and improvement. The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2013/14. This provided substantial assurance.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed through review of the internal audit plan and monitoring rate of achievement. No significant issues have been raised in-year although some issues have been raised by the Director of Finance in relation to the planning of audit work by KPMG.
An annual review of the effectiveness of internal audit.	KPMG has identified a number of performance areas against which the Committee can assess its performance and the timing of this assessment will be agreed with the Chair of the Committee.

Counter Fraud

The Committee shall ensure that there is an effective counter fraud service, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

	Progress
Consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.	See 3.1 above. The Trust's contract for internal audit services with KPMG includes provision of counter fraud services.
Review and approval of the Counter Fraud strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	KPMG presented a programme of work to the Committee in April 2014, which was approved. Progress against plan is reviewed at every meeting. The Committee received an annual report for 2013/14 in July 2014.
Consideration of the major findings of Counter Fraud (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives the Counter Fraud update report at each meeting to identify progress and any significant issues for action. The work of Counter Fraud is summarised in the annual report. KPMG undertook a proactive procurement review, reported to the Committee in July 2014, following guidance issued by NHS Protect that NHS organisations should review current arrangements around prevention and detection of procurement fraud. The review compared the current processes in place at the Trust with NHS Protect best practice in six areas relating to breaches of standing orders, standing financial instructions and EU public procurement directives, conflict of interest, bribes and kickbacks, false quotations and tenders, manipulating tender selection processes, and contract splitting. Six recommendations of medium priority were made and action agreed with the Trust.
An annual review of the effectiveness of Counter	Based on the self-review toolkit, the Trust is rated

Fraud Services.	**Progress** as green for strategic governance, red for inform and involve (the Trust was one of a number chosen by NHS Protect for a focussed counter fraud assessment focussing on the area of 'Inform and Involve' and the rating reflects the assessor's findings), amber for prevent and deter, and amber for holding to account. The recommendations from the assessor have been addressed and the focus for the Local Counter Fraud Specialist is to work with the Trust to continue to improve the quality assessment rating.

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	**Progress** During 2015, the contracts for both internal and external audit come to an end (KPMG (internal) 30 June 2015 and Deloitte (external) 30 September 2015). The Audit Committee considered the position at its meeting in October 2014 and was of the view that the Trust should not tender for both internal and external audit services at the same time. As there is no further option in the original tender to re-appoint Deloitte, a tender process will be undertaken during 2015 for external audit services. The Committee considered and agreed the plan for the process at its meeting in January 2015. The Members' Council was informed of the decision at its meeting in January 2015 and the Members' Council will be involved in the tender process.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan (January 2015). Progress against plan is monitored at each meeting.
Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The Audit Plan and fee for Deloitte was approved as part of the re-appointment process during 2013. As part of the negotiation of the fee during this process, the Trust received a reduction in the fee level to reflect that there was no requirement for Deloitte to incur tending or marketing expenditure for retention of the Trust's contract. A formal plan and fee proposal was presented to and approved by the Committee in January 2015.
Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: ➢ the statement for those with responsibility for governance in relation to 2013/14 accounts; ➢ final reports and recommendations as scheduled in the annual plan.

The Trust's external auditor, Deloitte, was selected for a Quality Review of Audits by the Quality Assurance Directorate of the Institute of Chartered Accountants of England and

Wales commissioned by Monitor. This was undertaken in August and September 2014 and the outcome reported to the Audit Committee in October 2014. There were no findings of significance and only minor disclosure issues raised, which will be addressed in the 2014/15 annual report and accounts process. Monitor has confirmed there were no issues it wished to raise with the Trust on 24 November 2014. As required, this has been reported to the Members' Council.

The Committee was presented with the external audit plan in January 2015. The Trust has strong risk management processes in place, which are embedded throughout the organisation. Notwithstanding this, three significant audit risks were identified by the Trust's external auditor, Deloitte. The following outlines the Trust's response to these risks.

- Recognition of NHS revenue – *fraudulent misstatement of revenue continues to be a presumed risk of misstatement.*
  Misstatement within financial statements continues to be a risk. There are processes in place to effectively manage income collection and reflect these accurately within the Trust's management accounts. The majority of Trust income relates to CCG commissioned services, which form the basis of a 'block' income. This is regulated through the contract negotiation process early in the financial year reducing the scope for variations between management accounts and financial accounts. Our system of internal control builds in segregation of duties and staff are appropriately qualified and trained. In addition, exercises such as the quarterly agreement of balances exercise provides cross-checking of inter-organisational income assumptions and flushes out areas where disputes may exist.

- Property valuations – *the valuation of the Trust's £96 million of property assets (as at 31 March 2014) is inherently judgemental.* This was identified as a continuing significant risk.
  The valuation of Trust property is undertaken by an independent and appropriately qualified external company appointed following a successful Trust procurement process, which included review of references and previous experience. We are provided with detailed reports and have the opportunity to discuss and understand any material changes. These reports provide the basis for adjustments and are the supporting documentation available to be reviewed by external audit.

- Accounting for capital expenditure – *the Trust has begun a significant programme of investment in community hubs.* Deloitte specifically highlighted the Calderdale community hub development at Laura Mitchell House in Halifax.
  The Trust continues to provide significant capital investment within its estate. For 2014/15, this includes the development of community hubs within Halifax and Barnsley. Expenditure on capital is reviewed on a monthly basis by both the finance and capital teams and reported into the Estates TAG and Trust Board. Staff undertaking these roles are appropriately qualified and experienced. In addition, discussions take place on more technically challenging aspects, with external audit colleagues, as soon as a query arises.

- Management override of controls – *Deloitte will use computer-assisted audit techniques to support its work on the risk of management override.*

Other Governance Duties

Standing Items for each Meeting

The Committee has reported on the following as standing items at each meeting to provide assurance to the Board that the Trust has complied with Trust regulations and Standing Orders.

- Review of internal audit progress reports.
- Review of losses and special payments.
- Review of counter fraud progress report.
- Review of external audit activity.
- Treasury management report.
- Procurement report, which monitors non-pay spend and progress on tenders.
- Triangulation report of risk, performance and governance.
- Review of progress towards implementation of service line reporting and currency development. This has included assurance on operational implementation and use from BDU Directors.

The Committee is also required to receive a report on any waiver of Standing Orders. Any waivers in relation to procurement are reported at each meeting through the procurement report and considered by the Committee. During 2014/15, there have been no other waivers of Standing Orders.

As part of its regular review of Treasury Management, the Committee reviewed the Treasury Management Strategy and Policy and recommended its approval to Trust Board in January 2015.

Ad-hoc and annual items

An internal audit of financial management was presented to the Committee in April 2014 and provided a substantial assurance audit opinion. This audit included a robust review of the Trust's implementation of the recommendations arising from the procurement (non-pay) purchasing audit and KPMG was able to provide a clean Head of Audit Opinion for 2014/15.

The Committee also:

- reviewed the external audit report on the production of Quality Accounts for 2013/14. (It should be noted that the scrutiny of the Quality Accounts themselves is a responsibility of the Clinical Governance and Clinical Safety Committee.);
- reviewed the process for the development of the Assurance Framework;
- considered the external agencies annual report for 2013/14 for assurance that the Trust acts on reports, etc. received; and
- received assurance on the outcome of the process in place to ensure staff make appropriate declarations of interest and supported the areas identified for development and improvement.

Annual items – financial reporting

In discharging its duties in relation to financial reporting the Committee has received the following reports as part of its remit.

- Received and approved annual report, annual accounts and Quality Accounts for 2013/14 and received and approved the annual accounts and annual report for Charitable Funds for 2013/14.
- Received the report from External Audit for those charged with governance, which outlines findings of external audit.
- Reviewed the Use of Resources Assessment for 2013/14.
- Reviewed and approved changes to the Trust's Accounting Policies.
- Reviewed the Procurement Strategy, priorities and progress against achievement of cost savings.
- At the request of Trust Board, received assurance on financial reporting.
- Received a briefing on the outcome of the quality review of audits by the Quality Assurance Directorate of the Institute of Chartered Accountants of England and Wales (see section 3.3 above).

Governance Assurance

Review of Audit Committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining the achievements against objectives and compliance with Terms of Reference. The Committee reviewed a first draft of its own annual report, work programme and terms of reference at its meeting in January 2015. The work programme was approved.

In January 2015 at the request of the Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. The Committee compared well against identified best practice and a number of actions were identified by the Company Secretary for further development. These have been agreed with the Chair of the Committee as follows.

1. Consult Members' Council on Audit Committee terms of reference. The best way to do this will be discussed with the Chair of the Trust during 2015.
2. Receive a presentation from Director of Human Resources and Workforce Development on the Trust's arrangements for whistleblowing to provide assurance to the Committee and, as part of this, consider a confidential/anonymous telephone number to report concerns.
3. Presentation to Members' Council on Trust Board Committees. This will form part of the session for the Members' Council on holding Non-Executive Directors to account in October 2015.
4. Discuss with Chair (and then Members' Council Co-ordination Group) an effective way of reporting to governors any matters where action or improvement is needed.
5. Establish rolling log for Committees rather than meeting specific. This will be introduced from April 2015 for all Committees.
6. Develop Committee cover sheet for Trust papers. This will be introduced from April 2015 for all Committees.
7. Develop a key issues template for providing assurance to Trust Board. This will be introduced from June 2015.

There were also a number of minor points of best practice in relation to the Committee terms of reference as follows.

1. Stronger narrative around scrutiny of the effectiveness of control arrangements and arrangements for staff to confidentially raise concerns.
2. Statement on the responsibility to develop and implement a policy on the provision of non-audit services;
3. Clarifying the Committee's role and relationship with the Members' Council, as articulated in Monitor's Code of Governance; and
4. Specify that the Committee undertakes an annual review of its effectiveness (this is already included in the existing terms of reference).

The Chair of the Committee asked for a review of the existing terms with recognised best practice (Healthcare Financial Management Association Audit Committee Handbook and NHS Providers Foundations of Good Governance). The existing terms of reference were found to be fit for purpose against both and it was agreed to consider the points raised above during the coming year following wider discussion and consultation with the Chair of the Trust.

In line with recommended best practice, the Audit Committee provides the following assurance to Trust Board.

- The Annual Governance Statement in consistent with the view of the Committee.
- Whilst the committee is not responsible for overall risk management within the Trust, it is satisfied that the system of risk management in the organisation is adequate.
- The Assurance Framework is reviewed by Trust Board quarterly and is considered to be fit for purpose. The Committee can assure Trust Board that it believes the processes for consideration and approval to be adequate.

- There are no areas of significant duplication or omissions in the systems of governance in the organisation that have come to the Committee's attention, which have not been adequately resolved.

The Trust's external auditor, Deloitte, was commissioned to undertake work in addition to its external audit activity to provide an independent and professional evaluation of the Trust's financial plan and, in particular, an assessment against the Trust's cost improvement programme. Deloitte has also been commissioned to undertake an independent review of the Trust's governance arrangements against Monitor's well-led framework, which is outside of the external audit brief. To maintain auditor objectivity, independence and probity, this work is being carried out by Deloitte staff who are not involved in the Trust statutory audits, nor do the audit staff have any involvement with the findings, which are reported directly to the Trust and not via the audit partner.

Clinical Governance and Clinical Safety Committee

The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice, and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice.

Members during 2014/15

Ian Black, Chair of the Trust (from June 2014)	Attended four out of four meetings
Bernard Fee, Non-Executive Director (to 26 May 2014)	Attended two out of two meetings
Julie Fox, Non-Executive Director	Attended six out of six meetings
Helen Wollaston, Non-Executive Director (Chair)	Attended six out of six meetings
Adrian Berry, Medical Director (from 1 October 2015)	Attended two out of two meetings
Nisreen Booya, Medical Director (to 30 September 2014)	Attended four out of four meetings
Tim Breedon, Director of Nursing, Clinical Governance and Safety (lead Director)	Attended six out of six meetings
Alan Davis, Director of Human Resources and Workforce Development	Attended four out of six meetings
Dawn Stephenson, Director of Corporate Development (in role as Company Secretary)	Attended five out of six meetings

Mental Health Act Committee

The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty.

Julie Fox, Non-Executive Director (Chair)	Attended four out of four meetings

Jonathan Jones, Non-Executive Director	Attended three out of four meetings
Helen Wollaston, Non-Executive Director	Attended three out of four meetings
Adrian Berry, Medical Director (from 1 October 2014)	Attended one out of two meetings
Nisreen Booya, Medical Director (to 30 September 2014)	Attended one out of two meetings
Tim Breedon, Director of Nursing, Clinical Governance and Safety (lead Director)	Attended four out of four meetings
Dawn Stephenson, Director of Corporate Development (in role as Company Secretary)	Attended three out of four meetings

Committee assurance

An internal audit of corporate governance arrangements was undertaken by KPMG in autumn 2014 and reported to the Audit Committee in October 2014. The audit provided an audit opinion of significant assurance with minor improvement opportunities and enabled Trust Board to take assurance that the arrangements in place around Corporate Governance, and in particular the Trust's Corporate Governance self-certification and self-assessment against external standards, are generally sufficient.

Seven low risk recommendations were made although these were not vital to the achievement of the Trust's strategic aims and objectives. The review also found that the Trust had responded to the best practice recommendations made in the previous review in 2013 to enhance what was already a good position.

Other Board-level Committees

Charitable Funds Committee

The Trust is a Corporate Trustee for its charitable funds. As a result, it is required to set up a mechanism for the management and use of these funds to ensure it fulfils its obligations as a Corporate Trustee and to manage the Trust's charitable funds in accordance with statutory requirements and Department of Health guidance. The Committee was set up as a body separate from the Audit Committee in November 2003 following a report on the management of charitable funds in the NHS by the Audit Commission.

Due to the unique nature of this Committee, members are invited to join and must undertake training in the administration of charitable funds in order to discharge their duties. The principle remains, however, that the Committee is chaired by a Non-Executive Director and membership includes other Non-Executive Directors.

Other Board-level Groups

Estates Forum

The Estates Forum was established by Trust Board in May 2011 and its prime purpose is to provide assurance to Trust Board on the development and implementation of the Trust's Estates Strategy. The Forum is chaired by a Non-Executive Director and has Non-Executive and Executive Director membership.

Information Management and Technology Forum

The Information Management and Technology Forum was established by Trust Board in September 2012 and its prime purpose is to provide assurance to Trust Board on the development and implementation of the Trust's Information Management and Technology

Strategy. The Forum is chaired by a Non-Executive Director and has Non-Executive and Executive Director membership.

Towards the end of the year, the Board approved the establishment of a further non-executive director-led forum to focus on diversity and inclusion to address a potential area of risk.

Monitor's Code of Governance

South West Yorkshire Partnership NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Practice, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Our Members' Council

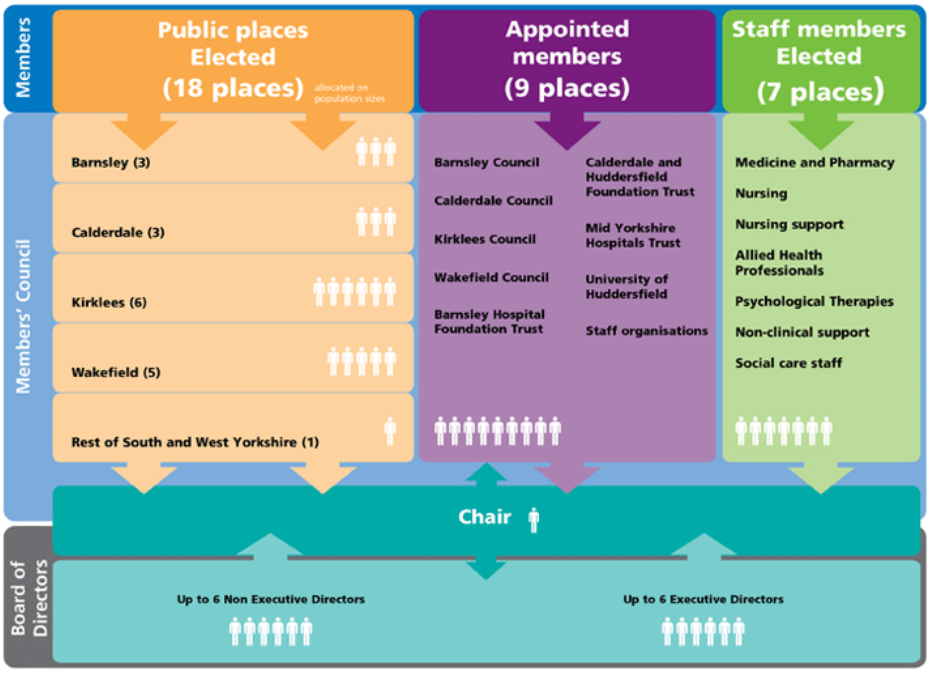
As set out in the Health and Social Care Act 2012, the Members' Council has a duty to hold the Non-Executive Directors of the Trust individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the members of the Foundation Trust as a whole and the interests of the public. As a Trust, we work to ensure our governors are equipped with the skills and knowledge they need to fulfil their duties.

The Members' Council also has a number of specific duties, which are to:

- appoint and remove the Chair and other Non-Executive Directors;
- agree the remuneration and allowances, and other terms and conditions of office, of the Chair and other Non-Executive Directors;
- approve the appointment (by Non-Executive Directors) of the Chief Executive;
- appoint and remove the Trust's financial auditors;
- be presented with the annual accounts, any report of the financial auditors on them and the annual report;
- provide views to Trust Board when it is preparing any document containing information about the Trust's forward planning (an influencing role; it is not telling the Trust Board what it should do or setting strategy);
- respond, as appropriate, when consulted by Trust Board; and
- prepare and, from time to time, review the Trust's membership strategy and its policy for the composition of the Members' Council and of the Non-Executive Directors, and, when appropriate, make recommendations for the revision of the constitution.

The Members' Council is made up of elected public representatives of members from Barnsley, Calderdale, Kirklees, Wakefield and the rest of South and West Yorkshire, elected staff representatives, and appointed members from key local partner organisations. It provides an important link between the Trust, local communities and key organisations, sharing information and views that can be used to develop and improve services. The Members' Council is chaired by the Chair of the Trust, who ensures appropriate links between the Members' Council and the Trust Board.

There are 34 places on the Members' Council made up as follows.



Lead Governor

The role of the Lead Governor is to:

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

Tony Wilkinson, publicly elected governor for Calderdale, was re-appointed as Lead Governor by the Members' Council from 1 May 2013 following successful re-election as a governor. At the start of 2015, he indicated that he wished to stand down as Lead Governor from 1 May 2015 to enable a smooth transition and to offer help and support to a new Lead Governor before his term of office ends on 30 April 2016. The Chair will present a proposal to the Members' Council in April 2015 for a successor.

Our governors

The table below sets out the governors in place as at 31 March 2015. Information on the elections held early in 2015 can be found in the next section.

Name/representing	Term of office	Attendance during 2014/15
Lead Governor		
WILKINSON, Tony Elected – public Calderdale	1 May 2010 for three years Re-elected 1 May 2013 for three years	Attended three out of four meetings
Governors		
ADAMOU, Marios Elected – staff medicine and pharmacy	1 May 2012 for three years	Attended two out of four meetings
ASKEW, Jean Appointed Wakefield Council	8 July 2014	Attended three out of three meetings
BAINES, Stephen Appointed – Calderdale Council	3 October 2014	Attended three out of three meetings
BREARLEY, Hilary Appointed Barnsley Hospital NHS Foundation Trust	17 July 2012	Attended four out of four meetings
BROWNBRIDGE, Garry Elected – staff psychological therapies	1 May 2014 for three years	Attended two out of three meetings
CRAVEN, Jackie Elected – public Wakefield	1 May 2014 for three years	Attended two out of three meetings
CROSSLEY, Andrew Elected – public Barnsley	1 May 2014 for three years	Attended three out of three meetings
DALE, Doug Elected – public Wakefield	1 May 2009 for three years. Re-elected 1 May 2012 for three years	Attended none out of four meetings
DEAKIN, Adrian Elected – staff nursing	1 May 2012 for three years	Attended three out of four meetings
EDWARDS, Netty Elected – staff nursing support	1 May 2012 for three years	Attended none out of four meetings
FENTON, Michael	1 May 2014 for three years	Attended two out of three

Name/representing	Term of office	Attendance during 2014/15
Elected – public Kirklees		meetings
GIRVAN, Claire Elected – staff allied health professionals	1 May 2012 for three years	Attended four out of four meetings
HASNIE, Nasim Elected – public Kirklees	1 May 2011 for three years Re-elected 1 May 2014 for three years	Attended four out of four meetings
HAWORTH, John Elected – staff non-clinical support	1 May 2012 for three years	Attended four out of four meetings
HILL, Andrew Elected – public Barnsley	1 August 2011 for 2.5 years Re-elected 1 May 2014 for three years	Attended four out of four meetings
KLAASEN, Robert Elected – public Wakefield	1 May 2012 for three years	Attended one out of four meetings
MANKU, Manvir Appointed staff side organisations	18 December 2014	Attended none out of one meeting
MASON, Ruth Appointed Calderdale and Huddersfield NHS Foundation Trust	8 November 2011	Attended four out of four meetings
MORGAN, Margaret Appointed Barnsley Council	1 January 2012	Attended one out of four meetings
MORTIMER, Bob Elected – public Kirklees	1 May 2009 for three years Re-elected 1 May 2012 for three years	Attended three out of four meetings
O'HALLORAN, Cath Appointed University of Huddersfield	1 June 2014	Attended one out of three meetings
PRESTON, Jules Appointed – Mid-Yorkshire Hospitals NHS Trust	13 June 2013	Attended three out of four meetings
REDMOND, Daniel Elected – public Calderdale	1 May 2014 for three years	Attended two out of three meetings
RIGGETT, Kevan Elected – public Barnsley	1 May 2013 for three years	Attended two out of four meetings
SMITH, Jeremy Elected – public Kirklees	1 May 2009 for three years Re-elected 1 May 2012 for three years	Attended four out of four meetings
SMITH, Michael Elected – public Calderdale	1 May 2010 for three years Re-elected 1 May 2013 for three years	Attended four out of four meetings
WALKER, Hazel Elected – public Wakefield	1 May 2011 for three years Re-elected 1 May 2014 for three years	Attended four out of four meetings
WALKER, Peter Elected – public Wakefield	1 May 2010 for three years Re-elected 1 May 2013 for three years	Attended four out of four meetings
WOODHEAD, David Elected – public Kirklees	1 May 2010 for three years Re-elected 1 May 2013 for three years	Attended three out of four meetings

The following governors left the Members' Council during 2014/15.

Name/representing	Term of office ended/reason
ADAM, Shaun Elected – public Barnsley	30 April 2014 Not re-elected
BAINES, Stephen Appointed – Calderdale Council	11 June 2014 Resigned (re-appointed 3 October 2014)
ISHERWOOD, Margaret Appointed Wakefield Council	7 July 2014 Resigned
PADGETT, Kath Appointed – University of Huddersfield	31 May 2014 Retired from University of Huddersfield
RIGBY, Dave Elected – public Kirklees	30 April 2014 Did not stand for re-election
SEAL, Barry Elected – public Kirklees	Resigned

Name/representing	Term of office ended/reason
WHARMBY, Laura Appointed – staff side organisations	2 October 2014 Resigned
WILKINSON, Adam Appointed Calderdale Council	2 October 2014 Resigned

Interests declared by governors can be found on the Trust's website at Members' Council register of interests. Contact can also be made with our governors through the website at Members' Council contact.

Our governors receive no payment for their involvement with the Trust on Members' Council business. We are required to indicate in our annual report the expenses paid to our governors in the financial year and the sum paid in 2014/15 was £2,101.09 to eleven governors (against a total of £2,608.22 in 2013/14).

Elections

Nominations for election to the Members' Council were sought in early 2015 for terms of office beginning 1 May 2015. The following seats were offered for election.

Publicly elected
Barnsley – one seat
Kirklees – three seats
Wakefield – two seats
Rest of South and West Yorkshire – one seat

Staff elected
Allied health professionals – one seat
Medicine and pharmacy – one seat
Non-clinical support staff – one seat
Nursing – one seat
Nursing support – one seat
Staff working in integrated teams – one seat

- In Barnsley, there were no candidates for one seat and the seat remains vacant.
- In Kirklees, there were two candidates for three seats and Bob Mortimer (re-elected) and Susan Kirby were elected unopposed. One vacant seat remains.
- In Wakefield, there was one candidate for two seats and Chris Hollins was elected unopposed. One vacant seat remains.
- In the rest of South and West Yorkshire, there were no candidates and the vacancy remains.
- For staff medicine and pharmacy, there was one candidate for one seat and Marios Adamou was re-elected unopposed.
- For staff non-clinical support, there was one candidate for one seat and John Haworth was re-elected unopposed.
- For staff nursing, there was one candidate for one seat and Adrian Deakin was re-elected unopposed.
- For staff nursing support, there was no candidate and there is now a vacancy.
- For the staff seat for social care staff working in integrated teams, there was no candidate and the vacancy remains.

The outcome of the election for the seat for Allied Health Professionals has yet to be confirmed.

Members' Council involvement and engagement

The Trust continues to have regard to the reviews of its Members' Council in a number of ways by offering a range of events and opportunities for governors to share their views and engage with Trust Board, particularly in the development of the Trust's annual plan. As part of their role in holding Non-Executive Directors to account, the Chair encourages governors to attend public Trust Board meetings. Those governors who have attended have welcomed the opportunity to do so and found attendance useful in helping them to understand the way Trust Board works, to understand more about the issues Trust Board considers and discusses, and to support governors in holding Non-Executive Directors to account. Governors will continue to be encouraged to attend meetings in the future. Trust Board members also attend Members' Council meetings.

At each meeting of the Members' Council, the Chair and Chief Executive present an overview of the key issues arising from Trust Board meetings together with a strategic overview of national, regional and local developments and the potential impact on the Trust. At each meeting, there is a round table discussion on key areas, such as the Trust's plans for transformation.

Holding non-executive directors to account for the performance of the board was a key area for governors and the discussion item in April 2014 provided a focus on supporting governors to do this. Each Non-Executive Director was asked to explain what they bring to the Trust in terms of their individual skills and experience, why they became a Non-Executive Director and why this Trust, and their role in the Trust. This exercise enabled governors to challenge non-executive directors on their role and contribution, and will be repeated in October of the coming year.

A joint meeting is held annually between Trust Board and the Members Council to look at the Trust's forward strategy. At the meeting in January 2015, the focus was on the Trust's plans for sustainability both in the coming year and over the next five years. In groups, governors and Directors were asked to identify risks and issues for sustainability and the impact on the five-year plan. The contribution from governors has informed and contributed to development of the Trust's annual plan for 2015/16. Key themes emerging related to continued working by the Trust in partnership with others, development of patient-centred, recovery-based services, a focus on co-production and alternative responses to service delivery, investment in recovery and prevention, and developing a flexible and diverse workforce.

All governors has an induction meeting with the Chair at the beginning of their term of office and an annual review. During the year the Members' Council was also involved in a number of other projects, including the following areas.

<u>Strategy and forward plans</u>

- Development of the Trust's Quality Accounts.
- Forward plan for 2015/16 (joint meeting with Trust Board) in January 2015.
- Consulted on the transformation of Trust services.

<u>Statutory duties</u>

- Re-appointment of the Chair.
- Appointment and re-appointment of Non-Executive Directors.
- Foundation Trust Network training for the appointment of Non-Executive Directors.
- Determination of Non-Executive Directors' remuneration.
- Received the annual report and accounts.
- Appointment of the Trust's external auditor.

Trust activity

- Involvement in judging for Excellence 2014.
- Engagement on Trust plans for transformation
- Attendance at dialogue groups across the Trust.
- Attendance at members' education events.
- Involvement in Trust unannounced visits and the pilot for the '15-steps' initiative.

Personal development

- Evaluation of the contribution of the Members' Council and governors both individually and collectively.
- Attendance at Foundation Trust Governors' Association meetings.
- Attendance at FTGA/NHS Providers network and regional governors' meetings.
- Attendance at the NHS Providers GovernWell training and development modules.

There are three standing working groups.

- The Nominations Committee is responsible for overseeing the process to appoint the Chair, Non-Executive Directors, Deputy Chair/Senior Independent Director and Lead Governor.
- The Co-ordination Group co-ordinates the work and development of the Members' Council.
- The Quality Group to review and develop the Trust's Quality Accounts and to review in more detail the Trust's performance.

Membership and engagement

We have an excellent track record and reputation for public involvement and engagement and firmly believe that working with our members, people who use our services and their carers, our staff and our stakeholders will help secure the most effective and responsive services for local people. We are determined to make the most of the opportunities that membership affords us to engage with people living in the communities we serve to make sure our services meet local needs.

Public membership

Any individual who lives in Barnsley, Calderdale, Kirklees and Wakefield who is aged 11 or over may become or continue as a member of the Trust. Late in 2013, this was extended to include the rest of South and West Yorkshire. Membership is not permitted for individuals who, within the last five years, have been involved as a perpetrator in a serious incident of violence at any of the Trust's hospitals or facilities or against any of our employees or other persons who exercise functions for the purposes of the organisation.

As at 31 March 2015, we had 11,042 public members. This is broken down as follows.

Barnsley	1,720
Calderdale	1,857
Kirklees	4,505
Wakefield	2,960

The Trust's approach to membership is to maintain a level of 1% of the population of Barnsley, Calderdale, Kirklees and Wakefield to ensure that our membership is representative of the communities within these local authority areas, and to work towards an engaged and committed membership. At the end of the year, membership was at 1% of the population it serves. Involvement of members who have expressed an interest in being involved in the Trust has remained constant through the year at 40% against a target of 50%.

The Trust measures its membership by ethnicity, gender, age and socio-economic group. The Trust is well-represented when compared with the makeup of its local communities and has excellent representation across most groups. The focus for recruitment of members has historically been to engage with our service users and their carers. As a result, young people aged between 11 and 14, older people over 85, and socio-economic group E are underrepresented in our membership. The Trust does, however, have a good track record of reflecting the ethnic diversity of the communities it serves in its membership.

Recruitment initiatives focus on engagement and involvement activity to enable members of the public and service users and carers to be able to influence the development and improvement of services.

Our approach to membership has four key strands to:

- maintain a representative membership in Calderdale, Kirklees and Wakefield (1% of population of each);
- continue to recruit towards target 1% of population of Barnsley and ensure it is representative of the local community;
- focus on recruiting members who want to be involved and engaged;
- ensure and encourage an involved and active membership.

This approach is supported by our new vision for volunteering, which was approved by our Board early in 2015 and was co-produced with staff and volunteers. We now have approximately 250 volunteers within the Trust. Volunteer roles include:

- health champions;
- befrienders, co-producers and co-facilitators in recovery colleges;
- expert patient programme volunteers;
- meet and greet volunteers;
- horticulture volunteers ;
- conversation buddies in speech and language service; and
- catering volunteers.

The vision is supported by a re-designed and simpler volunteer recruitment process, which was also co-developed with volunteers. Volunteers recruited from now on are automatically Trust members.

The Trust is a member of the NHS National Association for Volunteer Services Mangers, which will enable sharing of good practice and learning from others as well as national policy. The Trust has also committed to the Investing in volunteering accreditation assessment, which will begin in June 2015. Another development will be the establishment of volunteer lounges, the first being on the Fieldhead site.

Staff membership

Trust staff automatically become members of our Trust; however, they can choose to opt out of membership should they wish to do so. As members, they can influence future plans, use their vote to elect a representative onto the Members' Council or stand for election themselves. Staff are encouraged to be actively involved as members of the Trust and to promote membership to friends and family. Staff membership is broken down as follows:

Allied Health Professionals	609
Medicine and Pharmacy	202
Non-clinical support	1,096
Nursing	1,601
Nursing support	1,139
Psychological Therapies	197
Social care staff working in integrated teams	71

Our annual members' meeting

The Trust held its fifth annual members' meeting in November 2014. Over 100 people attended the event at Artworks in Halifax. The theme of this year's event focused on the use of creative approaches and activities in healthcare. Presentations and performances during the showcase and the meeting highlighted how creative activity can increase self-esteem, provide a sense of purpose, develop social skills, help community integration and improve quality of life. We also shared examples of how we are developing community partnerships and opportunities for people to get more involved in the work of our Trust.

Involvement, consultation and engagement

During the year the Trust continued it successful series of educational insight events for members, which provided an opportunity for members to find out more about mental and other health problems. These events are led by Trust clinicians and provide an opportunity to listen to an educational talk on a particular condition, followed by time for questions. These focused on insight into depression and anxiety, and learning disabilities.

Through the year, the Trust conducted a range of engagement activity to involve people who use services, their carers, Trust members and the public in influencing our plans for service

change. A specific focus in the year was on acute and community mental health services, including single point of access, care closer to home, and home based treatment. The Trust also involved service users, carers and the public in work to establish recovery colleges across our localities to support self-care and self-management and ensure educational, recreational and creative opportunities exist to support improved health and wellbeing. Engagement on general community services also took place to inform future service plans.

There are processes for ongoing involvement through groups and forums and through specific projects, and with the broader membership through information shared through education and information events and through the Trust's website. Engagement with local authority Overview and Scrutiny Committees was also a priority through the year, with links to Scrutiny Chairs and Scrutiny work programmes.

In 2015/16, the Trust will continue to move from a maintenance service model to a recovery-focussed model, and will continue engagement to facilitate improved access and a more person-centred approach to service delivery. This work is aligned to health and social care partner programmes. Detailed engagement on rehabilitation and recovery provision to inform an improved service offer will take place.

Other areas of engagement with our service users, their carers and other stakeholders are outlined below.

The Trust undertook the '15 Steps Challenge' across 28 in-patient services in October 2014. The Challenge is a toolkit to help understand what good quality care looks and feels like from service users' and carer's perspective and aligns with our values and quality priorities. The approach also supports the Care Quality Commission fundamental standards, PLACE (patient led assessment of the care environment), and supports the work we do in continually developing our services to provide excellent customer service measured by our achievement of the Customer Service Excellence (CSE)

The challenge teams were made up of a diverse group of people from service users to governors from our Members' Council with a remit to assess how welcoming, safe, caring and involving, well organised and calm our in-patient areas are. The overall analysis was very positive; however, there are a number of actions we will take to make our in-patient environments feel more welcoming, safe, more caring and involving, well organised and calm. The next series of visits are due to take place at the end of April 2015 to re-assess our in-patient areas and allow us to see where improvements have been made.

The Trust was accredited against the Rainbow Tick during 2014/15. The accreditation has informed an action plan to ensure that staff, service users and carers who identify as lesbian, gay, bisexual or transgender (LGBT) can feel safe and welcomed in Trust services. Since being awarded the tick, stickers have been sent out to services that have already demonstrated their practice is inclusive of this community, highlighting to people who visit their services that they will be treated with respect and dignity. A booklet, due to be finished in April, has been compiled with the input of people who identify as LGBT for circulation to services across the Trust offering a practical guide on how to be LGBT 'friendly'.

The friends and family test is in operation across all services within the Trust and we receive an average of around 750 responses a month. The question posed relates to how likely a service user would be to recommend a service to friends and family if they needed similar care or treatment.

Staff are also asked the same question with an additional question relating to how likely they are you to recommend the Trust to friends and family as a place to work. This is fed into the staff 'wellbeing at work' survey.

The Trust achieved Customer Service Excellence accreditation in July 2013 with a review in 2014, which saw the Trust maintain its accreditation. We will be reviewed again in 2015 and will be able to demonstrate the progress we are making to continually build on and improve our customer service practices.

The Trust is progressing plans to establish community hubs, accessible and modern facilities in support of the care closer to home agenda. Construction and re-development work is underway in Calderdale and Barnsley, with appropriate sites also being identified in the Wakefield and the surrounding district. In the year, the Trust will move services from the former Castleford, Normanton and District Hospital (CNDH) site and the Keresforth site (both predominantly administrative bases) and dispose of surplus land to re-invest in modern, fit for purpose community provision. In respect of the CNDH site, the Trust is in dialogue with a private provider to provide Tier 4 child and adolescent mental health services on the site, with the Trust providing specialist clinical input into a privately provided facility. This would offer a suitable health legacy for the site and offer a much needed service to children and young people in the region. In relation to the Keresforth site, the current learning disability day service, run by Barnsley Metropolitan Borough Council, will remain on the site.

Continued connection to commissioners and local authority Overview and Scrutiny Committees around emerging plans will advise the need for formal consultation on any service change deemed significant.

No formal consultations have been undertaken in the past two financial years and there are no consultations in progress at the date of this report.

Consultation with local groups and organisations, including local authority Overview and Scrutiny Committees covering membership areas and other involvement activities

The Trust has an established model of good practice around engagement with service users, carers and our broader membership on new projects and larger developments as follows.

- Initial ideas and discussions are taken to relevant service user or carer groups and specifically created engagement forums and events.
- Sub-groups consisting of people with a particular interest might be formed to undertake more detailed work, drawn from service user involvement, membership and volunteering.
- Updates on progress are offered to established groups and forums.
- In parallel to this process, Equality Impact Assessments are undertaken and service users and carers are involved in any action plans developed from the equality issues identified.

Connection to local authority Overview and Scrutiny Committees has been maintained throughout 2014/15 by attendance at formal meetings in line with Committee work programmes and through regular update meetings with each committee Chair and lead officer.

Nominations Committee

The Nominations Committee's prime purpose is two-fold. Firstly, to ensure the right composition and balance of the Board and, secondly, to oversee the process for the identification, nomination and appointment of the Chair and Non-Executive Directors of the Trust, to oversee the process for the identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board, and to oversee the process to identify, nominate and appoint the Lead Governor of the Members' Council. The Committee met four times in the period covered and its membership was as follows.

Marios Adamou, Members' Council (staff election – medicine and pharmacy) (from May 2014)	Attended one out of three meetings
Ian Black (Trust Chair) Chair of the Committee	Attended four out of four meetings
Nasim Hasnie, Members' Council (publicly elected – Kirklees) (from May 2014)	Attended three out of three meetings
Ruth Mason, Members' Council (appointed – Calderdale and Huddersfield NHS Foundation Trust) (from October 2014)	Attended two out of three meetings
Steven Michael (Trust Chief Executive)	Attended one out of four meetings
Kath Padgett, Members' Council (appointed – University of Huddersfield) (to May 2014)	Attended one out of one meeting
Michael Smith, Members' Council (publicly elected – Calderdale)	Attended three out of four meetings
Tony Wilkinson, Members' Council (publicly elected – Calderdale)	Attended four out of four meetings

The Nominations Committee works in accordance with the Trust's Constitution and has a process in place for the appointment of the Chair and Non-Executive Directors.

- Guided by the Chair, the Nominations Committee, on behalf of the Members' Council, reviews the balance of skills, experience and knowledge on the Board to ensure it remains fit for purpose as a unitary board of a Foundation Trust. This takes into account the needs of the organisation, the skills and experience within the Executive Director function and future developments that would affect the skills and experience required. This is reviewed at least annually.
- If appropriate, the Nominations Committee works with external organisations, recognised as experts at appointments, to identify candidates with appropriate skills and experience required for Chair and Non-Executive Director vacancies.
- Appropriate candidates are identified by the Nominations Committee through a process of open competition, which takes account of the above approach and the skills and experience required.
- The Nominations Committee is made up of the Chair of the Trust (or, when a Chair is being appointed, another Non-Executive Director), the Chief Executive, a minimum of two governors selected by the Members' Council and the Lead Governor. The Nominations Committee has the power to co-opt other governors, to appoint external organisations or individuals to offer advice and/or support to the Committee, and to co-opt individuals to act as independent assessors.

The Nominations Committee has overseen the process, supported by Penna, to appoint Non-Executive Directors to replace Peter Aspinall and Helen Wollaston whose terms of office will come to an end on 30 April and 31 July 2015 respectively. The Committee took

the decision to seek to recruit one individual with commercial and business development skills, an individual with third or voluntary section experience. Following a robust and open recruitment process, the Members' Council appointed Charlotte Dyson from 1 May 2015, Chris Jones from 1 August 2015 and Rachel Court from 1 September or 1 October 2015. following a recommendation from the Nominations Committee.

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

A recommendation to re-appoint Julie Fox as a Non-Executive for a further three years from 1 August 2014 was approved by the Members' Council in April 2014. A recommendation to re-appoint the Chair of the Trust from 1 May 2015 was approved by the Members' Council in January 2015.

The Nominations Committee has also considered the appointment of a Deputy Chair and Senior Independent Director to replace Helen Wollaston at the end of her term of office in July 2015. The Members' Council approved a proposal at its meeting in April 2015 to appoint Julie Fox to the role from 1 August 2015 for the remainder of her term of office.

Section 3 – Remuneration report

The Remuneration and Terms of Service Committee has delegated authority from our Board to:

- develop and determine appropriate pay and reward packages for the Chief Executive and Executive Directors, and a local pay framework for senior managers that actively contribute to the achievement of the Trust's aims and objectives;
- approve any termination payments for the Chief Executive and Executive Directors;
- ratify Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports the strategic development of human resources and workforce development, and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues.

Ian Black, Chair of the Trust (Chair)	Attended seven out of seven meetings
Jonathan Jones, Non-Executive Director	Attended seven out of seven meetings
Helen Wollaston, Non-Executive Director	Attended seven out of seven meetings
Steven Michael, Chief Executive (non-voting member)	Attended seven out of seven meetings

The Chief Executive and Executive Directors are appointed by the Remuneration and Terms of Service Committee on behalf of Trust Board. These appointments are ratified by the Members' Council. Trust Board agrees an appropriate appointment process to suit the needs of the appointment and the Trust. Directors' remuneration is also determined by this Committee.

Alan Davis, Director of Human Resources and Workforce Development, provides advice and guidance to the Committee, and the Committee is provided with administrative support by the Integrated Governance Manager. During the year, the Committee sought advice from Capita on Executive Director remuneration to ensure fairness, openness and transparency in its consideration of the Trust's Executive Director remuneration. This did not include consideration of the Chief Executive's remuneration. The report enabled the Committee to ensure Executive Director salaries are fair as well as being sufficient to attract, retain and motivate Directors of the quality required to run the organisation successfully but to avoid paying more than is necessary. No other external support or advice was sought by the Committee during 2014/15.

Performance related pay scheme

In 2010, the Committee agreed that a Performance Related Pay (PRP) Scheme should form part of the remuneration arrangements for Directors. The purpose of the Scheme would be to recognise and reward both the collective accountability for corporate performance and individual performance that exceeded what could reasonably be expected from an experienced and competent director.

As in previous years, the Scheme for 2014/15 comprised two elements. Firstly, three gateway corporate objectives designed to link to the Trust's medium and short term strategic goals and, secondly, ten personal objectives for each director against which their individual performance is assessed. The overall maximum performance award for a Director is 10% of base salary with 5% available for gateway objectives and 5% for personal objectives.

The three elements of the gateway objectives are:

- effective financial management and planning (the Trust achieves a minimum Monitor financial risk rating of 3 or above);
- effective governance, maintaining compliance and service quality (achievement of a Monitor Governance Rating of green, achieving a positive Care Quality Commission Quality Risk Profile of green and/or neutral and maintaining the terms of the Trust's Licence); and
- service transformation, which should progress in line with timescales agreed by the Trust Board with a specific link to the integrated Business Plan.

The gateway award has three levels:

- level 1: achievement of all three gateway objectives would realise a performance award of 5% plus individual awards of up to 5%;
- level 2: achievement of two gateway objectives would realise a performance award of 2% plus individual awards of up to 5%; and
- level 3: achievement of less than two gateway objectives would realise a performance award of 0% and no individual awards.

Individual performance is assessed against ten personal objectives linked to the Trust's corporate objectives set by the Chief Executive. Although the individual objectives are linked to the corporate objective set by Trust Board, they also seek to promote and advance three key strategic goals:

- achieving excellence in service delivery;
- delivering the Trust's strategic goals; and
- sustainability.

Achievement will attract either 0.5% or 0.25% of base salary for each objective where performance is assessed as either 'outstanding' or 'exceeding' expectations respectively. A performance of 'satisfactory' or 'good' will attract no award. The Chief Executive's objectives have been agreed with and his performance will be assessed by the Chair.

Directors eligible for the 2014/15 performance-related pay scheme are the Chief Executive, the Director of Finance/Deputy Chief Executive, the Director of Nursing, Clinical Governance and Safety, the Director of Human Resources and Workforce Development, the District Service Directors for Barnsley and Wakefield, and Calderdale, Kirklees and Specialist Services, and the Director of Corporate Development. The Committee agreed that, if a new director joins the Trust part-way through the year but before 1 October, they would be eligible to join the Scheme pro-rata to the number of completed months. Directors must have completed at least six months and remain employed by the Trust on 31 March 2015. Directors who leave prior to 31 March 2015 will not be eligible for an award and their salary will not be included in the 7.5% paybill limit.

There are a number of control measures in place to ensure the Scheme continues to promote and reward performance that exceeds expectations or is outstanding. These are that:

- no director can receive total remuneration (that is, agreed base salary and PRP) within a year exceeding the maximum of the pay range for their post plus 10%;
- the total performance awards for all eligible directors cannot exceed 7.5% of the total eligible directors' paybill where all three gateway objectives are achieved; and
- the total performance awards for all eligible directors cannot exceed 4.5% of the eligible directors' paybill where only two of the three gateway objectives are met.

The Chief Executive informed the Committee in April 2015 that it was likely that the three gateway objectives would be achieved; therefore, it was likely that the Committee would approve payments to Directors under the scheme.

In June 2015, the Committee will consider a report from the Chief Executive on the outcome of his end-of-year reviews with Directors in relation to the ten personal objectives as well as a report from the Chair on the Chief Executive's performance.

In July 2015, the Committee will consider the Trust's approach to remuneration for the coming year, particularly in relation to the performance-related pay scheme for Directors for 2015/16. It is likely that this will follow the format of the Scheme in previous years linking payment to the achievement of corporate and individual objectives. The detail of the scheme and the performance measures will be agreed by the Committee.

We are required to indicate in our annual report the expenses paid to our directors in the financial year and the sum paid in 2014/15 was £11,461.56 to eleven directors (against a total of £11,569.13 in 2013/14 to twelve directors).

Pay framework

The pay policy framework remains that the terms and conditions for staff reflect nationally determined arrangements under Agenda for Change. The Committee has agreed to wait for the outcome of the national review of the employer-based Clinical Excellence Award scheme before taking any decisions about the Trust's future approach. The Committee's wish that the scheme rewards clinical excellence linked to delivery of the Trust's strategic goals and contribution to leadership and management arrangements remains.

The Trust intends to introduce a senior managers' local pay framework covering staff on Agenda for Change bands 8c and above, which would take them outside of national terms and conditions. The aim of the framework would be to support the achievement of the Trust's objectives, attract, retain and motivate high calibre staff, link reward to performance and support delivery of high quality care, and ensure pay is fair, justifiable and meets equal pay principles. The approach would initially mirror national terms and conditions but without automatic incremental increases to provide sufficient time to review local terms and conditions and performance arrangements for senior managers outside of Agenda for Change. This approach will be further developed in the coming year.

During the year, the Committee approved five business cases for termination of employment on the grounds of redundancy at a senior level. This reflects the Trust's policy to reduce management costs to protect front-line services, involving the streamlining of both support and operational services at senior management level and to introduce new management arrangements. There were no significant awards made to past senior managers.

Details of appointment dates for Non-Executive and Executive Directors of the Trust are included in the table under the Trust Board section above. Non-Executive Directors are usually appointed for a three-year term and can be re-appointed for further terms up to a maximum of nine years; however, it is the view of the Chair that Non-Executive Directors should serve a maximum of six years other than in exceptional circumstances. There are no Executive Directors appointed on fixed term contracts. All Executive Directors are subject to a three-month notice period; however, this is currently under review by the Committee. No provision for compensation for early termination is included in staff contracts and any provision for compensation for termination would be considered on an individual basis by the Committee.

Accounting policies for pensions and other retirement benefits and details of senior employees' remuneration can be found below and are also set out in note 8 to the accounts. Apart from Non-Executive Directors who are appointed for a fixed-term, no other Directors of the Trust are appointed on fixed term contracts; therefore, there are no unexpired terms and contracts do not contain provision for early termination of a contract.

The information contained on pages 67 to 70 relating to the salary and pension entitlements of senior managers within the Trust is subject to audit and is taken from the Trust's accounts for 2014/15.

Non-Executive Director remuneration

In April 2014, the Members' Council considered a proposal on Chair and Non-Executive Director remuneration from a small sub-group made up of governors established to look at the remuneration of Non-Executive Directors. The sub-group agreed to commission an independent review of Non-Executive Director remuneration and engaged CAPITA to undertake this work. The sub-group supported the finding that the basic rate set in 2009 was still appropriate; however, the sub-group did recognise that the basic rate set in 2009 was based on a contractual time commitment of between 2 and 2.5 days per month. The latest Non-Executive Director appointment has an increased contractual time commitment of between 2.5 to 3 days per month. It was felt that the increase in contractual time commitment was significant and reflected the additional complexities and challenges now within these roles. It was the view of the sub-group that there was, therefore, a rationale to support an increase based on additional contractual time and a small increase was proposed from £12,500 to £13,250 per annum as recognition of an additional two days commitment per year. This was approved by the Members' Council.

There was no change to the Chair's remuneration at this time; however, an independent review will be commissioned from CAPITA to review Chair remuneration in other organisations for further consideration in 2015.

Leadership and management

This year has seen a number of changes to the Trust's leadership and management arrangements. During the year, the Trust's Medical Director indicated she wished to retire. The Chief Executive, in consultation with the Chair of the Trust, initiated a recruitment process and handover, which was managed positively and effectively, resulting in the appointment of an experienced clinician and operational Director to take on the role. The new Medical Director's experience at Board level minimised any risk to the organisation at Executive Director level and demonstrated the Trust's ability to foster and utilise skills and experience at senior level.

Also during the year, the changes initiated in 2013 to the Director structure at operational level to ensure strong and effective strategic and operational management within each BDU whilst maintaining a strong local focus continued to develop. These were strengthened by the appointment of deputy directors to provide operational leadership and management, allowing BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. Through 2014/15, this has been supported by arrangements at service line level to provide a framework where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

Following an interim appointment at Director-level to cover service improvement, innovation and health intelligence, the Committee supported a proposal from the Chief Executive to

create a permanent post to provide a focus on health intelligence and innovation and, following a recruitment process, the interim appointment was made substantive.

The Chief Executive has adopted a prudent approach to Director-level appointments over the past year; however, the Trust is entering a difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. In the coming year, the Chair and Chief Executive will jointly review the Trust Board structure to ensure it has the appropriate capacity, skills and experience in place within the parameters of its Constitution to support sustainability and ongoing fitness for purpose.

The Trust's organisational development framework allows work to be tracked in terms of effectiveness and this has been developed further during the year through regular review at Director-level led by the Chief Executive. From this Framework, a number of workstreams have been developed, launched and implemented to ensure the Trust has a workforce fit for the challenges in the future, such as the Talent Pool, the Magnificent 7 and a values-based recruitment, induction and appraisal programme.

One key aspect of this framework has been the recognition by the Trust of the need to develop home-grown leadership and management talent through effective leadership and development processes given the lack of suitable external candidates for posts at various levels within the organisation, enabling the Trust to recognise talent where it emerges across the organisation. The Chief Executive established the Talent Pool early in 2013 and this continues to flourish with staff getting involved in projects and initiatives within the Trust outside of their current job roles. The Talent Pool provides an opportunity for staff working in clinical and non-clinical support services to develop and stretch their knowledge, abilities and skills. By signing up to the Talent Pool, staff make a personal commitment to a programme of self-reflection and learning so they can make a difference to the quality of service delivered and increase their personal effectiveness. In the coming year, the Trust will begin to identify key roles where the Trust needs to grow individuals to fill posts internally and identify who these individuals are. The Committee supports the Chief Executive in both these developments.

As 2014/15 saw the Trust enter a critical point in its development, the Chief Executive commissioned a review of the Quality Academy to ensure fitness for purpose to support BDUs in the current challenging climate. The review made a number of sensible and constructive recommendations for the development of the Trust's approach to support and corporate services and these will be taken forward where there is potential to make a difference.

Off payroll arrangements

The Trust is required to disclose the following information in relation to any off-payroll arrangements in place as at 31 March 2015 and any new arrangements entered into in 2014/15.

TABLE 1: For all off-payroll engagements as of 31 March 2015 for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2015	17
Of which:	
- number that have existed for less than one year at the time of reporting	7
- number that have existed for between one and two years at the time of reporting	5
- number that have existed for between two and three years at the time of reporting	1
- number that have existed for between three and four years at the time of reporting	1
- number that have existed for four or more years at the time of reporting	3
Confirmation that all existing off-payroll engagements, outlined above, have, at some point, been subjected to a risk-based assessment as to whether assurance is required that the	Yes

TABLE 1: For all off-payroll engagements as of 31 March 2015 for more than £220 per day and that last longer than six months	
individual is paying the right amount of tax and, where necessary, that assurance has been sought.	

TABLE 2: For all new off-payroll engagements or those that reached six months in duration between 1 April 2014 and 31 March 2015 for more than £220 per day and that last for longer than six months	
Number of new engagements or those that reached six months in duration between 1 April 2014 and 31 March 2015	7
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	7
Number for whom assurance has been requested	7
Of which: - number for whom assurance has been received - number for whom assurance has not been received - number that have been terminated as a result of assurance not being received	 7 0 0

TABLE 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2014 and 31 March 2015	
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	2
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements.	18
For the above, details of the exceptional circumstances that led to each of these engagements and details of the length of time each of these exceptional circumstances lasted.	The Trust has two off-payroll engagements relating to board members and/or senior officials with significant financial responsibility during the financial year. One off-payroll engagement relates to one of our Non-Executive Directors, who is a partner in an international law firm (Squire Patton Boggs). They allow time for him to fulfil his Non-Executive Director duties and the monies are paid direct to the Squire Patton Boggs. The Non-Executive Director does not receive any direct payment and his tax arrangements are dealt with through Squire Patton Boggs. This has been the case since his appointment on 1 June 2010. He was re-appointed for a further three years on 1 June 2013 so the arrangement will effectively end on 31 May 2016. Squire Patton Boggs invoices the Trust for the remuneration. (It should be noted that Non-Executive Directors are not 'salaried'; they receive remuneration for their work and are not employees of the Trust although, with this one exception, Non-Executive Directors are paid through the Trust's payroll.) The second off-payroll engagement relates to the engagement of support at Director-level to provide leadership and operational management at a senior level to the Trust's child and adolescent mental health and forensic services, and to provide capacity within the Trust's senior team. This is an interim Director-level post designed to address a number of operational issues within the child and adolescent mental health service. The individual

TABLE 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2014 and 31 March 2015	
	engaged is an experienced senior manager and the engagement will end on 30 September 2015.

Steven Michael
Chief Executive

37 Salary and Pension entitlements of senior managers

37.1 Remuneration

The Salary and Pension entitlements of senior managers are set by the 'Remuneration and Terms of Services Committee' which is a sub-committee of the Trust Board. The members of this committee in 2014/15 were: Ian Black (Chair of the Committee, Chair of the Trust), Jonathan Jones (Non-Executive Director of the Trust), Helen Wollaston (Non-Executive Director of the Trust), Steven Michael (Chief Executive) with Alan Davis (Director of Human Resources & Workforce Development) in attendance and Bernie Cherriman-Sykes who is committee secretary.
The Trust follows national guidance on pay and terms and conditions for Senior Managers and the contracts are substantive contracts with NHS termination arrangements.

Name and Title	31/03/2015						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Ian Black, Chair	40 - 45	4.0			2.9		50 - 55
Bernard Fee, Non-Executive Director (Left 26/05/14)	0 - 5				0.6		0 - 5
Peter Aspinall, Non-Executive Director	15 - 20				1.2		15 - 20
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director	15 - 20						15 - 20
Julie Fox, Non-Executive Director	10 - 15				1.3		10 - 15
Laurence Campbell, Non-Executive Director (Joined 01/06/14)	10 - 15				0.5		10 - 15
Steven Peter Michael, Chief Executive	170 - 175	2.0			0.6	17.5 - 20.0	190 - 195
Nisreen Hanna Booya, Medical Director (Left 30/09/14)	15 - 20			55 - 60			70 - 75
Alan George Davis, Director of Human Resources and Workforce Development	110 - 115	2.8				97.5 - 100.0 *	215 - 220
Alexandra Farrell, Deputy Chief Executive/Director of Finance	120 - 125		0 - 5			47.5 - 50.0 *	175 - 180
Dawn Stephenson, Director of Corporate Development	85 - 90	5.3	0 - 5		0.2	(55.0 - 57.5) *	40 - 45
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	105 - 110	1.1	0 - 5		0.2	80.0 - 82.5 *	195 - 200
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	30 - 35	5.7		110 - 115	2.2	140.0 - 142.5 *	285 - 290
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		0 - 5		1.1	(5.0 - 7.5)	100 - 105
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100		0 - 5		1.4	(5.0 - 7.5)	95 - 100
Nette Carder, Interim District Director, CAMHS and forensic services (from 05/01/15)	35 - 40						35 - 40
Diane Smith, Interim Director of Service Innovation and Health Intelligence (secondment from NHS England to 31/12/14)	85 - 90						85 - 90
Diane Smith, Director of Service Innovation and Health Intelligence (Substantive from 01/01/15)	20 - 25					(27.5 - 30.0)	(5 - 10)

Name and Title	31/03/2014						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Ian Black, Chair	45 - 50				2.6		45 - 50
Bernard Fee, Non-Executive Director	10 - 15				0.8		10 - 15
Peter Aspinall, Non-Executive Director	15 - 20				1.1		15 - 20
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director	15 - 20				0.2		15 - 20
Julie Fox, Non-Executive Director	10 - 15				1.7		10 - 15
Steven Peter Michael, Chief Executive	165 - 170	2.6	5 - 10		0.2	72.5 - 75.0	245 - 250
Nisreen Hanna Booya, Medical Director	30 - 35			80 - 85			110 - 115
Alan George Davis, Director of Human Resources and Workforce Development	95 - 100	2.9	0 - 5		0.2	15.0 - 17.5	120 - 125
Alexandra Farrell, Deputy Chief Executive/Director of Finance	110 - 115		0 - 5		2.3	12.5 - 15.0	135 - 140
Dawn Stephenson, Director of Corporate Development	90 - 95		0 - 5		0.7	(267.5 - 270.0)	(165 - 170)
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	95 - 100	0.8	0 - 5		0.4	35.0 - 37.5	135 - 140
Anna Basford, District Service Director, Calderdale and Kirklees (Left 04/07/13)	25 - 30	1.1	0 - 5		0.3	12.5 - 15.0	45 - 50
Adrian Berry, Director of Forensic Services	25 - 30	9.1		100 - 105		0 - 2.5	135 - 140
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		0 - 5			7.5 - 10.0	110 - 115
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100	0.5	0 - 5		1.1	(27.5 - 30.0)	70 - 75
Diane Smith, Interim Director of Service Innovation and Health Intelligence (Joined 09/01/14) (Secondment from NHS England)	10 - 15						10 - 15

	31/03/2015	31/03/2014
Band of Highest Paid Director's Total Remuneration (£000's)	170 - 175	190 - 195
Median Total Remuneration* £'s	27,306	27,463
Remuneration Ratio	6.4	7.0

The Remuneration Ratio is a comparison of the highest paid director and the median remuneration of all staff. The Median Total Remuneration and the Remuneration Ratio do not include the value of Pension Related Benefits in their calculation.

* There are a number of large increases in the pension related benefits field. The main reasons for these changes are noted below.

Alan George Davis, Director of Human Resources and Workforce Development	Impact of salary change from 2013 / 2014 to 2014 / 2015
Alexandra Farrell, Deputy Chief Executive/Director of Finance	Impact of salary change from 2013 / 2014 to 2014 / 2015
Dawn Stephenson, Director of Corporate Development	Impact of salary change from 2013 / 2014 to 2014 / 2015
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	Impact of salary change from 2013 / 2014 to 2014 / 2015
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	Impact of new role secured during 2014 / 2015

The Trust operated a Performance Related Pay scheme (PRP) for Directors. The scheme in 2014/15, which is non attributable and non pensionable and has a maximum value of 10%, provides for a maximum award of 5% for achieving all three Gateway Objectives and discretion for the Remuneration and Terms of Service Committee to award 2% where 2 out of the 3 are achieved. If one or no gateway objectives are achieved no performance awards are made. PRP above that awarded for achievement of gateway targets is recommended by the Chief Executive, based on the appraisal of the individual Director performance and approved by the Remuneration and Terms of Service Commitee to a maximum of 5%. In 2013/14 the award was a one off bonus, which is non attributable and non pensionable and has a maximum value of 6%. Eligibility for PRP requires the Trust to achieve 3 gateway objectives which entitle the Director to 1.5% performance award. PRP above 1.5% is recommended by the Chief Executive, based on the appraisal of individual Director performance and approved by the Remuneration and Terms of Service Committee.

For 2014/15 the accounts include £100k accrual as an estimate for the award of PRP which related to 2014/15 performance. The PRP award will be proposed by the Chief Executive and will be approved by the Remuneration and Terms of Service Committee in 2015/16. This will be disclosed in detail in the remuneration report in the 2015/16 accounts.

The Annual Performance Related pay in 2014 / 2015, disclosed in the table above, relates to payments made in 2014 / 2015 for performance in 2013 / 2014 which was approved by the Remuneration and terms of service Committee in 2014 / 2015.

Other remuneration for 2014/15 relates to payment for substantive clinical posts held within the Trust.

Expenses for 2014/15 are predominately the reimbursement of travel expenses.
The benefits in kind relate to child care vouchers, relocation expenses, cycle to work scheme, staff lease cars, NHS Phone Scheme or expenses paid in accordance with the Trust's Removal Expenses Policy (which includes provision of accommodation).

2013/14 Pension related benefits have been restated following updated guidance from Monitor which clarified the Pension related benefits calculation. A summary of this movement is shown in the table below.

	Restated 13/14	Original 13/14	Movement
Steven Peter Michael, Chief Executive	72.5 - 75.0	15 - 20	55.0 - 57.5
Alan George Davis, Director of Human Resources and Workforce Development	15.0 - 17.5	5 - 10	10.0 - 12.5
Alexandra Farrell, Deputy Chief Executive/Director of Finance	12.5 - 15.0	5 - 10	7.5 - 10.0
Dawn Stephenson, Director of Corporate Development	(265.0 - 267.5)	(40 - 45)	
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	35.0 - 37.5	5 - 10	32.5 - 35.0
Anna Basford, District Service Director, Calderdale and Kirklees (Left 04/07/13)	12.5 - 15.0		12.5 - 15.0
Adrian Berry, Director of Forensic Services	0 - 2.5		0 - 2.5
Sean Rayner, District Service Director, Barnsley and Wakefield	7.5 - 10.0	0 - 5	2.5 - 5.0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	(27.5 - 30.0)	(0 - 5)	(25.0 - 27.5)

* The median remuneration is the total remuneration of Trust staff member(s) lying in the middle of the linear distribution of the total staff, excluding the highest paid director. This is based on annualised, full-time equivalent remuneration as at the reporting period date.

.....Steven Michael, Chief Executive..... 22-May-15

37.2 Pension Benefits

Name and title	Normal retirement age	Real increase/ (decrease) in pension and related lump sum at retirement age (bands of £5000) £000	Total accrued pension and related lump sum at retirement age at 31 March 2014 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase (Decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension Rounded to 1 decimal place £000
Steven Peter Michael, Chief Executive	60	7 - 10	255 - 260	1,223	1,124	68	0
Alan George Davis, Director of Human Resources and Workforce Development	60	20 - 25	190 - 195	987	831	133	0
Nisreen Hanna Booya, Medical Director (Left 30/09/14)*		-	-			-	0
Alexandra Farrell, Deputy Chief Executive/Director of Finance	60	10 - 15	140 - 145	689	597	76	0
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	65	5 - 10	85 - 90	506	413	81	0
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	55	25 - 30	225 - 230	1,060	824	131	0
Dawn Stephenson, Director of Corporate Development	60	(5 - 10)	145 - 150	745	739	(13)	0
Sean Rayner, District Service Director, Barnsley and Wakefield	60	0 - 5	145 - 150	681	639	25	0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	55	0 - 5	165 - 170	786	738	28	0
Diane Smith, Director of Service Innovation and Health Intelligence (Substantive from 01/01/15)	60	(0 - 5)	135 - 140	721	785	(21)	0

* Nisreen Booya was in receipt of pension from 30/09/11 and so the pension, related lump sum and CETV is nil.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

.....Steven Michael, Chief Executive…… 22-May-15 Date

Section 4 – Our staff

The Trust's workforce is by far the largest area of expenditure and therefore represents our most important resource. This means a well engaged and motivated workforce will make the biggest difference to the lives of the people who use our service. It is their dedication, commitment and professionalism which enables the Trust to deliver services that enable people to reach their potential and live well in their community.

Therefore, the Trust's aim is to develop a value-based culture which makes our staff feel able and capable to deliver the best quality services possible within the resources available. This requires investment to ensure we recruit, retain, develop and motivate a representative workforce that has the right skills to continue to provide responsive, effective and safe mental health, learning disability and community services.

The staff turnover rate for the Trust for 2014/15 was 8.2%, which is within the target range of 5 to 10%. Trust Board set a target sickness absence rate of 4% for 2014/15; the end of year rate was 4.8%. Staff sickness data as required by the Cabinet Office will be published on the Trust's website.

The table below shows the staff in post by the different occupation groups as at 31 March 2015.

Staff in post by occupation group	2014/15 FTE	2014/15 Heads
Add professional, scientific and technical	243	292
Additional clinical services	906	1,070
Administration and clerical	819	989
Allied health professions	265	315
Estates and ancillary	292	380
Medical and dental	155	174
Nursing and midwifery registered	1,347	1,516
Students	4	4
Total	**4,031**	**4740**

NB it should be noted that these figures will differ from those reported on page 19 of the accounts. The above figures are at a point in time (31 March 2015) and those in the accounts represent an average over the financial year.

Equality and diversity			Staff as at 31.03.15
Age Band	Females	Males	Total
19 and Under	5	4	9
20 – 24	109	33	142
25 - 29	291	68	359
30 - 34	391	81	472
35 - 39	390	148	538
40 - 44	514	149	663
45 - 49	546	192	738
50 - 54	654	200	854
55 - 59	464	117	581
60 - 64	218	59	277
65 - 69	62	22	84
70+	14	9	23
Total:	**3,658**	**1,082**	**4,740**

Census Group	Grand Total
Asian	3.50%
Black	2.08%
Chinese or Other	0.85%
Mixed	0.89%
White	92.68%
Grand Total	**100.00%**

Statement of approach to staff engagement and feedback arrangements in place and key priorities and targets.

The Trust recognises that well-being and engagement of staff is a key factor in improving organisational performance and delivering high quality services.

The Trust has worked on a number of initiatives to promote employee engagement and develop the workforce in the last twelve months, including the following.

- Reviewing its approach to recruitment, induction, appraisal and leadership development to ensure the Trust's values are at the centre of these key workforce processes.
- Assessment centres have been delivered for Band 5 staff nurse vacancies and Band 3 support worker posts where multiple vacancies exist. Recruitment for senior leadership posts has incorporated the Trust's values within an assessment centre approach.
- The Trust has implemented a values-based Induction Policy working closely with staff side colleagues.
- The Trust has undertaken an evaluation and revised the value-based appraisal process.
- Developing a values-based approach to leadership competencies to reflect the new challenges ahead and a values based behavioural framework for all staff.
- Rolling out the Middleground 4 communication and engagement process for middle managers.
- Recognising individuals and teams through a 'Values into Excellence' programme.
- The Trust is undertaking a 'Transformation of the Support Worker Workforce' project in partnership with Skills for Health and further developing its apprenticeship scheme.
- The 'Well-being at Work' Partnership Group continued to be active and is made up of senior managers, clinical staff and staff side representatives to develop the well-being agenda. The Trust continued to receive regular feedback from staff and the latest results to the Trust's wellbeing at work survey are expected in May 2015, approximately 2000 staff gave their feedback. Colleagues also received a personalised well-being and resilience report providing advice and suggestions for managing their well-being at work.
- A stress management pathway has been developed to support staff and line managers to effectively manage work related and personal stress. In 2015/16 will be offering health checks to staff though the occupational health and well-being service.
- The Trust achieved Investors in People (IiP) re-accreditation in June 2012, is seeking to maintain accreditation and is also working towards Gold status.
- In 2015/16 the Trust will review its approach to staff engagement to seek continuous improvement in creating an engaged workforce.

Staff survey

The annual national NHS staff survey, which aims to improve the working experience in the NHS, was carried out in October 2014. The survey was sent to a randomly selected sample of 850 Trust staff. The response rate was 46%, which is above average compared with similar NHS organisations. The survey results are presented across 28 key findings.

The Trust's results were in the best 20% in the following key findings.

- % feeling satisfied with the quality of work and patient care they are able to deliver.

- % agreeing that their role makes a difference to patients
- Extent of work pressure felt by staff.
- % staff working extra hours.
- % experiencing discrimination at work in the last twelve months.

Response rate

2013		2014		Trust position
Trust	National Average	Trust	National Average	
50%	50%	46%	42%	Above average

Top 5 ranking scores

	2013		2014		Trust position
Top five ranking scores	Trust	National average	Trust	National average	
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	82%	77%	84%	76%	Best 20%
% Experiencing discrimination at work in the last 12 months	8%	13%	9%	12%	Best 20%
% of staff agreeing their role makes a difference to patients	90%	90%	92%	89%	Best 20%
% of staff working extra hours	65%	71%	61%	71%	Best 20%
Work pressure felt by staff	2.93 scale score	3.07	2.92	3.07	Best 20%

There were three key findings where the Trust's results were in the worst 20%.

- % staff receiving health and safety training in the last twelve months.
- support from immediate managers.
- Reporting good communication between senior managers and staff.

Bottom 5 ranking scores

	2013		2014		Trust position
Worse five ranking scores	Trust	National average	Trust	National Average	
% of staff feeling pressure to attend work when feeling unwell	20%	22%	22%	20%	Worse than average
% staff receiving health and safety training in the last 12 months	57%	75%	65%	73%	Worst 20%
Staff motivation at work	3.84	3.84	3.78	3.84	Worse than average
% of staff reporting errors, near misses or incidents witnessed in the last month	87%	92%	88%	92%	Worst 20%
% reporting good communication between senior management and staff	27%	31%	26%	30%	Worse than average

Changes in the results since 2013

The Trust's results improved in the following areas.

- % having equality and diversity training in the last twelve months.
- Percentage of staff receiving health and safety training in the last 12 months, 65%, this has increased by 12% since last year.

The Trust results have worsened in the following area.

- Percentage of staff appraised in the last 12 months 91%, 96% in 2013, (this remains a better than average percentage)

Actions 2014 NHS Staff Survey

The Trust is developing an action plan in response to the NHS Staff Survey 2014, which will be overseen by the Wellbeing at Work Partnership Group. The group will also monitor progress in delivery of the action plan.

The action plan will focus on the four key areas where the feedback from staff identified that the Trust needed to improve and where the results were in the bottom 20% of Trusts. The three areas are as follows.

Health and safety training:

Percentage of staff receiving health and safety training in the last 12 months, 65%, this score is 8% below the national average. (This has increased by 12% since last year). During 2014/15 there were over 5500 attendances on safety related training, these figures exclude management of violence and aggression training. The process for booking mandatory training is being streamlined and the Trust is continuing to promote attendance at safety related training as a key priority.

Reporting of errors, near misses and incidents:

Percentage of staff reporting errors, near miss or incidents witnessed in the last month 88% reported. This is 4% below the national average. National reporting figures indicate the Trust has an average level of reporting. Training on reporting is provided to managers and at induction. The action is being reviewed further by the practice governance committee.

Communication between senior management and staff:

Percentage of staff reporting good communication between senior management and staff 26%, this is 4% below the national average. There are a range of processes for communication between senior management and staff. These include monthly updates to Extended Executive Management Team from the Chief Executive or Deputy, messages from the Trust Board and Executive Management Team, ad hoc roadshows / visits to services by Chief Executive and directors, a Communications sub group of the Trust wide Partnership Forum, weekly bulletins, internet and intranet which is subject to regular review. Further work will take place to understand where communication channels can be improved across the service.

Other local surveys/related workforce initiatives

The NHS Staff Survey results will be reviewed alongside the Trust's Wellbeing at Work survey results, the latest results are expected in May 2015. The Wellbeing at Work survey has been administered in partnership with Robertson Cooper, Occupational Psychologists. Wellbeing at work surveys have been undertaken since 2009.In addition, the NHS Staff Survey results will also be used by the Trust towards its commitment to achieve gold standard Investors in People accreditation.

Section 5 – Our Financial Position

Introduction

This section and the accounts have been prepared in line with appropriate guidance, including the Annual Reporting Manual for NHS Foundation Trusts 2014/15 and under a direction issued by Monitor under the National Health Service Act 2006. The Trust has also complied with the cost allocation and charging guidance issued by HM Treasury.

This is the second year in which the Trust has prepared Group accounts. This means that the Trust's charitable funds are included as part of the Group accounts and the Trust accounts can still be viewed in isolation.

Overview of financial performance 2014/15

The Trust had an annual turnover of £237.7 million for 2014/15 and an overall surplus of £3.1 million (1.3%) for the year. Of its total income, 83% is generated by healthcare contracts with local Health commissioners (Clinical Commissioning Groups (CCGs) in Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield) and 10% from local authorities. The majority of contract income is commissioned as a fixed payment; however, 2.5% (£4.7 million for 2014/15) is based on the achievement of key quality indicators. The Trust achieved 88% of the performance indicators.

The Trust met its requirements set out in its annual plan for 2014/15.

Income & Expenditure Performance for 2014/15		
	2014/15	**2013/14**
	£'000	£'000
Income from Activities	221,227	220,093
Other Operating Income	16,450	15,353
Total Income	237,677	235,446
LESS		
Operating Expenses	(231,883)	(230,253)
Interest Received	95	88
Public Dividend	(2,793)	(1,529)
Movement in fair value of investment properties	16	0
Surplus	3,112	3,752

The financial performance is scored by the regulator Monitor using the Continuity of Service Risk Rating. The score in the annual plan was 4; the score achieved was 4. The maximum score achievable is 4.

The Trust achieved a savings target of £12.9 million during the year, delivering the plan in full. This position was achieved with £10.1 million (78%) delivered as set out in the original programme and £2.8 million (22%) through mitigations and substitutions.

The capital budget was revised in year from the initial £11.8 million to £8.1 million. The actual expenditure was £6.1 million which is a £2 million (24%) variance compared to the revised plan. This capital programme delivered a number of notable schemes. The Fieldhead infrastructure scheme was completed providing a renewal of water ring mains and

mains electrical cables, which included inbuilt resilience for future projects alongside completion of improvements to inpatient facilities on the Fieldhead site within medium secure services. This year has also seen the commencement of significant capital investment in the Trust's estate with the development of community hubs in Calderdale and Barnsley. These hubs form a key element of the Trust's Estates Strategy and enable savings to be realised whilst delivering a higher standard of accommodation.

The Trust planned and maintained a healthy cash balance throughout the year with a balance of £32.6 million as at 31 March 2015. These cash funds have been built up over time to fund the future investment in estates and technology which are vital to the continued provision of sustainable services.

The Trust was not required to make any payments to suppliers under the late payment of commercial debts (interest) Act 1998.

Evidence of good practice in financial management

Treasury Management

As a Foundation Trust, the Trust is able to generate income by investing cash.

As a result of national changes to the calculation of Public Dividend Capital (PDC) in 2013/14, the Trust has not sought external investment of cash and has, instead, taken the decision to maintain all cash balances within the Government Banking Service (GBS). As a result, this has secured the best possible financial result for the Trust with savings in PDC being greater than interest that could have been secured from elsewhere. The positive cash position has facilitated this position.

The Trust manages its working capital balances making payments on due dates in line with the NHS Better Payment Practice Code.

The Trust's cash balance was sufficient to meet its operational and capital outgoings throughout the financial year.

International Financial Reporting Standards (IFRS)

As part of its annual work programme, the Audit Committee has reviewed the accounting policies applicable in 2014/15. The accounting policies were updated for any changes in national guidance. There were no significant changes which impacted on the Trust's reporting requirements or disclosure in the 2014/15 accounts.

Valuation of Assets

In line with the Trust's Accounting Policies, a periodic review of Trust estate has been conducted in 2014/15. This followed the full physical assessment of all estate undertaken in 2013/14. In doing so, the appropriate impairments (re-valuation impact both positive and negative) have been reflected within the Trust's accounts.

Recording of Investment Property

Estate which the Trust Board has declared surplus to requirements is recorded as investment property under IFRS and its value is updated annually to the current market value. As at 31 March 2015, these assets are Aberford Field, Southmoor and Hyde Park.

Pension Liabilities

The accounting policy for pensions and other retirement benefits are set out in Note 8 to the Accounts and the details of senior employees' remuneration can be found in Note 37 (the remuneration report) as well as in the Remuneration Report section of the annual report.

Auditors' Remuneration

Audit fees were £65,000. This covers both the Annual Accounts and Quality Accounts. The fee for independent examination of the charitable fund was £1,800. A further £30,000 was expended for additional work involving professional evaluation of the Trust's Financial Plan and in particular the assessment against the Trust's cost improvement programme.

Directors' Statement

The Directors of the Trust can confirm that all relevant information has been made available to the Foundation Trust's auditors, Deloitte LLP, for the purposes of its audit and, in addition, that they have taken all steps required to ensure their Directors' duties are exercised with reasonable care, skill and diligence.

At the time this report was approved, so far as any Director is aware, there is no relevant information of which the Trust's auditor is unaware. Each Director has taken all the steps they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Going concern

The Trust prepares an annual plan each year, which is approved by Trust Board and submitted to Monitor for review. For 2015/16, the detailed operational plan covered a one-year time scale only following a five-year plan submitted in June 2014.

As part of the plan preparation and approval process, Trust Board has considered, in detail, the Trust's position, reviewing the financial viability of the organisation in the challenging economic climate. On the basis of this review, the Trust continues to adopt the Going Concern basis in preparing the accounts.

Non-NHS income disclosures

The Trust has met the requirement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that requires that the income from the provision of goods and services for the purposes of the health service in England are greater that the Trust's income from the provision of goods and services for any other purposes. There has been no impact from 'other' income on the Trust's provision of goods and services for the purposes of the health service in England.

Key Financial Issues for the Future

The key issues for the Trust which will impact on future financial viability include the following.

- The continuing impact of reduced levels of funding for public sector services caused by the economic downturn both in health and social care, which creates the requirement for ongoing efficiency savings of 4% to 5% for the foreseeable future.
- The need to undertake transformational change in services to deliver different service models, which maintain quality at reduced cost, as creating further efficiencies and productivity gains in current service models will not be enough to meet the ongoing challenge.
- Work with commissioners and other providers to create sustainable pathways of care across providers, which are patient-centred, offer good outcomes and value for money.
- Sustained improvement in clinical record keeping and data quality to ensure clinical information technology systems support evidence of good quality care and value for money through the introduction of Payment by Results for mental health services.

The Trust continues to work in partnership with key stakeholders to develop a joint approach to delivering improved quality, innovation and productivity in services and prevention of ill

health, and to make best use of resources in a period of significant economic challenge. The Trust's partnerships include Clinical Commissioning Groups, local authorities and other NHS and non-NHS providers, including social enterprises.

The Trust has developed an internal transformation programme with key workstreams in mental health, forensic services, learning disability and community and wellbeing services. The aim of the Transformation Programme is to improve outcomes, deliver improved services and achieve best use of resources.

In 2015/16, our overall cost improvement requirement is £9.7 million. To reduce recurrent expenditure to meet this requirement, the Trust will have both a cost improvement programme and a transformation programme.

The Estates Strategy approved by the Trust Board remains the strategic framework for the capital plan in the coming year and specifically focuses on:

- development of community infrastructure;
- development of in-patient estate linked to acute care pathway;
- ensuring compliance with national standards and the requirements of our regulators; and
- disposal of surplus estate.

The capital programme is aligned to the Trust's long-term financial plan and provides for capital expenditure of £12 million in 2015/16. All new capital developments will be designed to support service transformation and will be based on agile working principles supported by greater use of information management and technology.

Section 6 – Other disclosures

Patient experience and customer services

Throughout 2014/15, the Trust placed increased emphasis on gaining insight into people's experience of using services to influence how services are organised and new services are planned. The Trust has established a customer experience group whose remit is to facilitate learning from customer experience, support improvement in line with our mission and values and ensure service users and carers are at the centre of all we do to enable the best possible outcomes.

The Trust's Customer Services Policy was revised in December 2014 to ensure it continued to reflect best practice in terms of national reviews and recommendations.

Revised reporting arrangements now include formal quarterly reporting to Trust Board on Trust-wide intelligence from the customer services function. Quarterly reports showing service line detail are also shared with Business Delivery Units for review and triangulation through locality governance processes. These reports are also shared with commissioners, along with contracting requirements and with HealthWatch across our geography. Monthly reporting on complaints regarding staff attitude continues as part of the Trust's performance reporting.

In 2014/15, the Trust received 265 formal complaints, 237 concerns, 162 comments, 824 compliments and 714 general enquiries. A further 399 issues were resolved at service level.

Not all complaints require action plans to remedy issues, but all provide helpful feedback, which is used in services to support service improvement. District Directors monitor the delivery of action plans and ensure that corrective action is implemented within service lines in response to trend analysis provided by Customer Services. All complainants received a detailed response to the issues raised and an apology where appropriate. In 2014/15, over 125 actions were implemented and changes made in response to feedback. These included:

- a community service in Barnsley has introduced a process to ensure family/carers have access to repeat prescriptions from GPs whilst service users are supported in in-patient settings;
- an IAPT service in Barnsley is reviewing the process to ensure that service users on the waiting list are kept updated;
- a health visiting team in Barnsley is reviewing the protocol for information sharing with other parties, for example, GPs and auditing of recorded documentation has also been introduced;
- ward staff on a Calderdale ward have been reminded about the need to protect confidentiality when discussions take place in shared/open areas;
- crisis service staff in Calderdale and Kirklees have been reminded about the importance of using clear communication with service users/carers and families, and to ensure that the information provided has been understood;
- staff in adult in-patient wards in Calderdale and Kirklees have been reminded that details regarding discharge and the discharge policy to be provided to service users in writing, in addition to discussion;
- staff from a Kirklees service will ensure that the carer and/or family involved in assisting the recovery of a service user are also offered assessment of their needs;
- a family's experience of receiving care has been shared with the crisis assessment team as a learning exercise, and the importance of appropriate and professional conduct when making contact with service users and families has been reiterated;

- in Wakefield, in-patient ward housekeeping staff and catering staff are reviewing the process to ensure that correct meals are delivered on a daily basis, with improved communication between the two functions;
- also in Wakefield, new processes have been introduced to ensure better coordination and communication between CMHT's and crisis services;
- staff in the 136 suite in Wakefield have been reminded about the value and importance of involving and listening to carers and family members during the assessment process;
- a range of improvements have been made in Barnsley, Calderdale and Kirklees child and adolescent mental health services in response to feedback
- in forensic services, the importance of explaining restraint and seclusion procedures to service users has been reiterated to ward staff.

The forensic team is building on recent positive feedback on involvement, including the One Voice Group, the unit-wide Carer's Dialogue Group and recent ward based family events. A ward manager is leading work to raise awareness of the importance of recording positive feedback from service users, to share good practice and to have this acknowledged through Trust processes.

Sustainability

We have evaluated our progress and approach to sustainability and agreed a new strategy for the next three years, with the overall purpose to provide a clear framework and vision of how the Trust will drive to integrate sustainability into its operations and its engagement with staff, service users and the communities we serve. The strategy sets out realistic, measurable targets under each of the three national goals and each of the Good Corporate Citizen assessment headings. Specific areas covered are energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment, adaptation, organisational and workforce development and partnerships and networks.

We continue to use the Good Corporate Citizenship model which echoes our belief in the importance of inclusion and co-production. Community engagement and workforce involvement are the cornerstones to success in all areas of our work. We know that we will only succeed if we continue to harness the commitment and support of our staff and volunteers to behave and work in a sustainable way.

We undertook an assessment using Good Corporate Citizenship model and our current score is 78%, which is very good and we compare extremely well against other organisations that have chosen to complete the assessment. We can improve in all areas but the main area for development is in transport, travel and access.

We have already met our target to reduce our levels of CO2 emissions (electricity and gas, car/motor travel, waste and water) by 18% by 2016 and have set another target for a further reduction of 34% by 2020 (from a baseline of 2010/11 levels).

We continue to procure our services using the whole life costing model and for the future we intend to stretch ourselves further by increasing the level of business engagement with local small/medium enterprises.

Equality and Inclusion

We are fully committed to supporting and promoting equality and diversity both in the way we provide services and as an employer. We aim to ensure that all our services are designed and managed to respect and value difference. Our Equality Report and other policies recognise that equality and diversity is core to the way we work and provide services. We must maximise people's potential through valuing their diversity and treating them equally. We acknowledge that people who come into contact with our services, or who

work for us, are individuals and are not defined by one aspect of their lives, whether this is their race, gender, sexual orientation, religion or any of the other protected characteristics.

Over the past twelve months, we have continued to undertake work to embed the four equality objectives based on the four equality goals from Equality Act 2010 and the Department of Health's Equality Delivery System 2 (EDS2).

As a Trust we need to:

- meet the needs of people from diverse backgrounds, paying particular attention to the nine protected characteristics of the Equality Act;
- recognise what those needs are and have the skills and resources to provide the right services; and
- not make decisions or mistakes based on stereotypes and ignorance.

By valuing equality, diversity and inclusion, recognising its importance in our services, our approach and our workforce will be able to meet the positive challenges associated with equality in the 21st century and maximise people's potential.

The Trust has policies in place to ensure that full and fair consideration is given to applications for employment made by disabled persons, having regard for their particular aptitudes and abilities. This includes the continuity of employment of, and arranging appropriate training for, employees who become disabled whilst in Trust employment, and for the training, career development and promotion of disabled employees. Details of the Trust's human resources policies can be found on the Trust's website.

This year we reviewed and refreshed the equality, diversity and inclusion training we deliver face-to-face for staff with input from Professor Uduak Archibong from the Centre of Diversity and Inclusion at Bradford University and the numbers of staff who attend this training are continuing to grow.

Research and development

2014/15 marked the beginning of an exciting new phase for Research and Development (R&D) at the Trust but it has not been without challenges. Several members of the R&D team left within the year to take up new roles elsewhere, which, despite creating some issues with capacity, gave us the opportunity to review the team structure and skill mix with an eye to the future needs of the team and our ambitions for R&D at the Trust in the future. Notwithstanding the significant reduction in staffing, the Trust was nevertheless able to approve, and provide support to, a total of 23 new studies in 2014/15 of which nine were part of the National Institute for Health Research (NIHR) Clinical Research Network's portfolio.

422 participants were recruited to 52 studies overall, which were open during the course of the year. Of these 422 participants, 316 were recruited to studies in the NIHR Clinical Research Network portfolio (representing 23 out of the 52 studies). 83% (5/6) of NIHR Clinical Research Network portfolio studies which closed in year were delivered to agreed recruitment targets in the timescales specified.

The R&D Department itself was brought into the new Health Intelligence and Innovation Directorate, a move that brings opportunity for greater collaboration across the Trust as a whole. The changes are the first step in helping us to achieve our aim of expanding the Trust's R&D activities and further embedding a culture of research and innovation within the organisation. We have recently appointed a new Research and Development Manager to lead the team and are actively recruiting new Clinical Research Officers, with the aim filling our vacancies early in 2015/16.

Closely allied to the internal changes is the development of our relationships with key partners and influencers in the wider research community. In 2014/15, the NIHR Clinical Research Network: Yorkshire and Humber was established and we have begun to forge close links with the new network with the aim of raising our external research profile and facilitating access to the necessary support and resources to help fulfil our objectives.

Statement of the Chief Executive's responsibilities as the Accounting Officer of South West Yorkshire Partnership NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of South West Yorkshire Partnership NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South West Yorkshire Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of South West Yorkshire Partnership NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of South West Yorkshire Partnership NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed… 

Chief Executive
22 May 2015

Annual Governance Statement 2014/15

Scope of responsibility

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

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

The attitude of Trust Board to risk is prudent and pragmatic, adopting a flexible approach to risk and determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and will determine its approach and its appetite for risk to suit the circumstances at the time.

Capacity to handle risk

The Trust has robust arrangements and frameworks in place to ensure it has the capacity to handle and manage risk.

One of the Trust's continued strengths is the stability of its Board.

An experienced and long-standing Non-Executive Director came to the end of his term of office in May 2014. One of the key considerations for the Nominations Committee, which has devolved responsibility from the Members' Council to oversee and manage the process to appoint the Chair and Non-Executive Directors, is to ensure effective succession planning. As a result, the Committee supported the Chair's view that the recruitment process should focus on recruiting an individual who could replace the current Chair of the Audit Committee, who leaves office in 2015. The recruitment process was successful and supported by an external recruitment consultant to ensure transparency and independence. The Members' Council approved the appointment of a new Non-Executive Director who joined the Trust on 1 June 2014 and assumed the Chair of the Audit Committee on 1 January 2015. This has been a successful and smooth transition minimising any risk to the organisation.

The Members' Council also approved the re-appointment of the Chair and one other non-executive director for a further three-year term to continue to provide stability and strength within the Board.

The coming year may prove more challenging in terms of changes to Non-Executive Directors on the Board. The Board will lose twelve years of Non-Executive experience during 2015 and the Chair does not under-estimate the gap this may leave as the Trust enters another challenging year. A process has begun, through the Nominations Committee, to appoint two new Non-Executive Directors for approval by the Members' Council in April 2015.

Towards the end of the year, the Board approved the establishment of a non-executive director-led forum to focus on diversity and inclusion to address a potential area of risk. The two existing forums, focusing on estates, and information management and technology, have continued their work through the year. All three forums ensure the Trust's strategy is developed and implemented, and that risk is managed effectively.

During the year, the Trust's Medical Director indicated that she wished to retire. As Chief Executive, and in consultation with the Chair of the Trust, I initiated a recruitment process and handover, which was managed positively and effectively, resulting in the appointment of an experienced clinician and operational Director to take on the role. The new Medical Director's experience at Board level minimised any risk to the organisation at Executive Director level and demonstrates the Trust's ability to foster and utilise skills and experience at senior level.

During the year, the changes initiated in 2013 to the Director structure at operational level to ensure strong and effective strategic and operational management within each BDU whilst maintaining a strong local focus continued to develop. These were strengthened by the appointment of deputy directors to provide operational leadership and management, allowing BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. Through 2014/15, this has been supported by arrangements at service line level to provide a framework where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

Following an interim appointment at Director-level to cover service improvement, innovation and health intelligence, with the support of the Remuneration and Terms of Service Committee, I created a permanent post to provide a focus on health intelligence and innovation and, following a recruitment process, the interim appointment was made substantive.

Although I have adopted a prudent approach to Director-level appointments over the past year, in consultation with the Chair, the Trust is entering a difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. In the coming year, the Trust Board structure will be reviewed to ensure it has the capacity, skills and experience in place within the parameters of its Constitution to support sustainability and ongoing fitness for purpose.

Trust Board continues to be ably supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has gone from strength-to-strength in its ability to challenge and hold non-executive directors to account for the performance of Trust Board. The agendas for Members' Council meetings focus on its statutory duties, areas of risk for the Trust and on the Trust's future direction. The Trust continues to develop its

approach to training and development to ensure governors have the skills and experience required to fulfil their duties in partnership with the Members' Council Co-ordination Group.

This year has seen the Trust lay the firm foundations for its ambitious transformational service change programme and associated structures to transform the way it delivers services. The programme will ensure the Trust continues to deliver services that meet local need, offer best care and better outcomes, and provide value for money whilst ensuring we remain sustainable and viable. Implementation of this programme as well as maintaining delivery of high quality and safe services has, again, presented the Trust with its biggest challenge in 2014/15. Four workstreams provide the framework, covering mental health services, learning disability services, general community services and forensic services. Each has a Director sponsor and clinical lead and is supported by robust project management arrangements through the Project Management Office. Although the scale and pace has made it hard to effect and enact fundamental change during the year, the work to develop the framework holds the Trust in good stead to achieve the pace of transformational change needed during the coming year.

The strategic framework for the organisational development (based on "What really works: the 4+2 formula for sustained business success" (Nohria, Joyce and Robertson)) continues to support operational delivery. The model provides a framework for principal objectives to be agreed and set by the Board, underpinning the Board assurance framework and implementation objectives determined in line with key executive director accountabilities. These objectives are reviewed by me with individual directors on a quarterly basis. Any resulting amendments to the Assurance Framework are reported directly into the Trust Board including any changes to the organisational risk register.

In October 2014, I developed an articulation of 'How the Organisation Runs', which reiterated our mission and strategic objectives, and clarified the roles and responsibilities at every level to deliver continued success. This was followed by a second phase in March 2015, which sets out a clear and simple model to describe the systems we operate within and how they interact, enabling the organisation to run to best effect. The model is based on the work of Dartmouth Institute in the USA, most notably, Dr Gene Nelson, who, through our ongoing relationship with Jönköping County Council in Sweden, has provided the basis for this model.

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

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

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

As 2014/15 saw the Trust enter a critical point in its development, I commissioned a review of the Quality Academy to ensure it is fit for purpose to support BDUs in the current

challenging climate. The review made a number of sensible and constructive recommendations for the development of our approach and these will be taken forward where I believe they can make a difference.

The organisational development framework has allowed work to be tracked in terms of effectiveness and this has been developed further through regular review. From this Framework, a number of workstreams have been developed, launched and implemented to ensure the Trust has a workforce fit for the challenges in the future, such as the Talent Pool, the Magnificent 7 and a values-based recruitment, induction and appraisal programme.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers through initiatives such as Creative Minds, joining the second phase of the Improving Recovery through Organisational Change (ImROC) initiative and developing recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

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

As Chief Executive, I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust recognises that in the medium- and longer-term, services across the local health economy are unsustainable in their current form. Therefore, the Trust has to work in partnership with other organisations to ensure that services are provided in the most effective way and that the Trust remains sustainable and viable.

The Trust has sound and robust partnership arrangements with the four local authorities in Barnsley, Calderdale, Kirklees and Wakefield and the five clinical commissioning groups covering Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield. Relationships have been fostered, developed and built on with commissioners. The Trust also has good working relationships with Local Area Teams at Director and senior management level. The relationship with the Secure Commissioning Group, covering the Trust's medium and low secure services, has again proved challenging during 2014/15 as national policy affects commissioning intentions locally. This has impacted on the Trust's forensic services, and maintenance of sound relationships locally is a critical factor in supporting the future success of these services.

All Executive Directors are fully engaged in relevant networks, including quality governance boards, nursing, medical, finance and human resources at local and regional level. Both the Chair and I attend national network meetings and I am the NHS Confederation elected Chief Executive representative on the Mental Health Network Board. I am also involved in the Care Quality Commission's new inspection process for mental health trusts, providing invaluable intelligence for the Trust.

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

The risk and control framework

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS Foundation Trust condition 4, which applies to Foundation Trusts only. An internal audit undertaken early in 2014, provided an opinion of substantial assurance on the arrangements that the Trust has in place for ensuring compliance with its Licence conditions, which supports assurance of the validity of the Corporate Governance Statement and is backed by a self-assessment at Board level of the arrangements the Trust has in place. This is supported by my Annual Governance Statement, risk management arrangements, and the Trust's annual plan. A review in early 2015/16 will include a risk assessment of the new licence condition in relation to integrated care.

Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust, and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary. Its attitude to risk is prudent and pragmatic, adopting a flexible approach to risk and determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and will determine its approach and its appetite for risk to suit the circumstances at the time.

As Chief Executive, I remain accountable, but delegate executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, while ensuring there is a high standard of public accountability, probity and performance management. Central to this process of quality assurance has been the development of the Quality Academy. The personal objectives of each director have clear risk and assurance statements attached to them. The Assurance Framework reflects the strategic objectives assigned to the Executive Directors.

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

Strategic risk is managed in line with the Trust's Risk Management Strategy, which was amended and approved by the Trust Board in January 2015 to ensure it remains fit for purpose. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in accordance with the principle to reduce risk to as low a level as reasonably practical. The Trust's risk matrix sets out those risks which, under this principle, are tolerable from those which are unacceptable.

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

The Trust's main risks as set out in the organisational risk register are as follows.

1. Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners. Mitigated by robust project management arrangements, engagement plans with commissioners and implementation plans reflected in contract monitoring agreed and in place, supported by the Data Quality Steering Group chaired by the Director of Nursing and BDU data quality improvement plans.

2. The volatile commissioning climate and its impact on the nature of the system of classification and associated currency currently under review could increase the level of risk for mental health services if cost and pricing mechanisms are not fully understood at local, regional and national level. Mitigated by established project management arrangements and formal working groups linked to commissioners in all areas, work on currency and benchmarking included in the mental health strand of the transformation programme to evidence benefits, and input and participation in Care Packages and Pathways programme nationally to share best practice, benchmark progress and support development.

3. Continued reduction in Local Authority funding and changes in benefits system will result in increased demand of health services due to a potential increase in demand for services and reduced capacity in integrated teams, which could create the risk of a negative impact on the ability of integrated teams to meet performance targets. Mitigated by dialogue with local authorities on solutions that maintain quality, participation in transformation programmes at system level to deliver improvements, creating opportunities to reduce reliance on the public sector through support for third sector providers, and development of the ImROC implementation plan in partnership with service users to promote recovery.

4. The planning and implementation of transformational service change through the transformation programme will increase clinical and reputational risk for delivery in-year through an imbalance of staff skills and capacity between the ‘day job’ and the ‘change job’. Mitigated by additional resources and external consultancy recruited to support the transformation programme, and key deliverables reviewed and monitored by EMT.

5. The Trust's financial viability will be affected as a result of changes to national funding arrangements (such as clinical commissioning group allocation and the Better Care Fund) coupled with emerging intensified local acute Trust pressures. The risk of local re-tendering will increase the risk in the 2015/16 contracting round for the level of savings required to maintain financial viability with potential to fragment pathways and increase clinical risk. Mitigated through active engagement in system transformation programmes, engagement of expertise to ensure capacity is in place and robust EMT review of commissioner intentions and contract management.

6. Bed occupancy is above that expected due to an increase in acuity and admissions and is causing pressures across all bed-based mental health areas across the Trust. Mitigated through development and implementation of a revised Bed Management Protocol with robust monitoring across all BDUs and a clear escalation process and clinical leadership, and robust actions to manage patient flow.

7. The Trust has identified a lack of robust systems and processes to support safe practice within inherited children’s and adolescents’ mental health services, including timely access and responses, and appropriate clinical interventions, mitigated by development of a robust recovery plan based on best practice and compliance requirements with timescales in place for delivery and with strong commissioner involvement.

8. The ongoing requirement to reduce costs and meet commissioner QIPP will result in the Trust becoming unsustainable clinically, operationally and financially by year four of the five-year plan. Mitigated by a tiered strategy to achieve sustainability, which assumes consolidation of pathways and efficiencies in existing services, substitution of current service models for recovery-based alternative service offers at lower cost, and strategic consolidation of key services to drive savings through critical mass.

The risks outlined above will continue into 2015/16 with mitigating action in place.

Innovation and learning in relation to risk management is critical. The Trust uses an e-based reporting system, DATIX, at Directorate and service line level, so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors. The Trust operates within a just, honest and open culture where staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes.

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

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

The Clinical Governance and Clinical Safety Committee monitors the implementation of recommendations arising from external agencies, such as the Francis Report and the Government's response, and Winterbourne View, independent inquiries and external reviews until actions have been completed and closed. The Clinical Review Group, chaired by the Director of Nursing, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the serious incident review process, associated learning, and subsequent impact within the organisation.

The provision of mental health services carries a significant inherent risk, resulting, on occasion, in serious incidents, which require robust and well governed organisational controls. During 2014/15, there were 106 SIs across the Trust compared to 101 SIs in 2013/14. The underlying trend for SIs is stable. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The independent review process in relation to three cases in Kirklees and a thematic analysis review to cover the learning outcomes from three previous Kirklees homicides that took place in 2007/08 is now complete. The report and action plan was published by NHS England, commissioners and the Trust on 23 January 2015 and the action plan will be implemented and monitored by the Clinical Governance and Clinical Safety Committee and by commissioners their Quality Board.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups, public involvement in the activities of our Trust, membership of the Trust and its Members' Council, and regular dialogue with MPs and other partners. The engagement events held by the Trust during 2014/15 to support its transformation programme have also provided an opportunity to involve service users, carers and stakeholders in the management of risk.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring equality impact assessments are undertaken and published for all new and revised policies and services. Any new or revised polices, strategies, service re-design and projects must undertake an Equality Impact Assessment before approval. This ensures that equality, diversity and human rights issues, and service user involvement are systematically considered and delivered on core Trust business. All commissioned services also have an Equality Impact Assessment. The Equality and Inclusion into Action Group ensures EIAs are fully mainstreamed into BDUs' performance framework.

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

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

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and a regular programme of unannounced visits. The experience gained from visits in 2013/14 has reinforced the organisational value of conducting the programme. Visit team findings have facilitated learning and provided teams with useful experience of an inspection process. Feedback reports are received and reviewed by BDUs with direction for action focused through BDU governance functions. Lessons learned from the process have been used to inform changes to the next planned visit programme. In 2014/15 the visit programme focused on assessment against both the CQC essential standards and the Trust's quality priorities. The focus of unannounced visits in 2014/15 has been on areas of risk and to follow up findings of previous visits. The programme has visited a range of services, both community and in-patient.

The Trust assessed itself against the NHS Constitution and a report was presented to Trust Board in September 2014. This covered all areas of the Trust. The Trust meets all the rights and pledges with the exception of the pledge "The NHS commits to make the

transition as smooth as possible when you are referred between services, and to include you in the relevant discussions". It meets this partly as the Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions when the nature of an individual's illness makes this inappropriate.

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

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Improvement Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board, co-ordinated under the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.
- There are quarterly quality reports for Trust Board and the Executive Management Team as well as monthly compliance reporting against quality indicators within performance reports. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of ECT, PICU and Memory Services; CQC Mental Health Act Visits, NHSLARMS status, national surveys (staff and service user), implementation of Essence of Care and Productive Ward, etc.)
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as SIs, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.

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

- Systematising the collection of service user and care feedback through kiosks and hand held tablets, with a consistent approach to action planning and communication of the response to feedback, including assessment against the Department of Health's Friends and Family Test.
- Review and implementation of the '15 Steps Challenge' in Barnsley involving service users and carers, and stakeholders, including staff.
- Production of 'How was it for you today' working with service users and staff toolkit to receive service user carer feedback of their experience in out-patient clinics.
- Series of engagement events for staff, service users and carers, and stakeholders on mission and values, and transformation programme.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- Principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.

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

The Trust maintained its Customer Service Excellence award for all areas in 2014.

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

The governance framework of the Trust is determined by Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its Committees, including the Audit and Remuneration and Terms of Service Committees, and the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Delivery EMT, BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting. In 2014/15, work also continued to develop the Trust's health intelligence function to support development of existing and new services. Work also continues both internally and with partners on the quality, innovation, productivity and prevention (QIPP) agenda.

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

The Trust's financial plan for 2014/15 was externally and independently reviewed by the Trust's external auditors, Deloitte, and a number of recommendations made. The report and actions arising from it were presented to Trust Board and progress against these recommendations monitored at each meeting. To support implementation of the 2014/15 plan and to ensure robust operational management is in place to manage Trust resources and to meet the plan, as Chief Executive, I established an Operational Requirement Group attended by Executive and operational Directors and their Deputies. The Group meets weekly and is chaired by myself. The Group supports the assurance provided to EMT and to Trust Board that there is strong management control over the Trust's resources and that risk is managed and mitigated.

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

In consultation with the Board, I asked Deloitte to review progress against the recommendations made for the 2014/15 plan and to review the financial plan for 2015/16. Deloitte found that, overall, the process had significantly improved. Development of the cost improvement programme showed a clear bottom/up approach with clear ownership within

and by BDUs. The risk assessment was thorough, was a good process, and was seen to be balanced. The depth and detail of the quality impact assessment and quality of challenge was commended and was seen to be rigorous, particularly compared with other organisations. The Quality Impact Assessment process was seen as a well-developed methodology for the Trust to understand the level of risk involved with each proposed cost saving.

In terms of the follow up to the 2014/15 review, the recommendations had been substantially implemented and completed or partially completed. Where only partially completed, this presented no material weaknesses. For the review of the 2015/16 plan, for the majority of schemes, Deloitte concurred with the Trust's assessment of risk to delivery in terms of outcome; however, by value of savings to be realised, Deloitte considers the risk to delivery to be higher.

During 2015, the arrangements for external and internal audit come to an end. In October 2014, the Audit Committee reviewed the Trust's current. For external audit, Deloitte was awarded a two-year extension to its contract from 1 October 2013. As this was all that was allowed for in the original tender, the Trust would be unable to negotiate a further extension with Deloitte and must re-tender for external audit services. The Committee was of the view that tendering for both internal and external audit services at the same time would present a risk to the organisation and agreed to an extension to the contract for KPMG as the Trust's internal auditors for one year and to re-tender for external audit services.

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

Information Governance

Information governance is a key compliance area for the Trust. Control measures are in place to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust SIRO (senior information risk owner). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2015 and messages on compliance with Trust policy have been backed up by regular items in the weekly staff news. Incidents and risks are reviewed by the Information Management and Technology Trust Action Group chaired by the Director lead for information governance, which informs policy changes and reminders to staff.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioners Office (ICO). Three incidents have been reported as meeting the threshold for external reporting under the new reporting requirements. One of these involved a wrongly addressed Compulsory Treatment Order in Kirklees and this is currently being followed up by the Information Commissioner's Office.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form

and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The following steps have been put in place to assure Trust Board that the Quality Report presents a balanced view and that there are appropriate quality governance arrangements in place to ensure the quality and accuracy of performance information. Quality metrics are reviewed monthly by Trust Board and the Executive Management Team and form a key part of the performance reviews undertaken by Business Delivery Units as part of their governance structures. The Clinical Governance and Clinical Safety Committee has delegated authority from Trust Board to oversee the development of and approve the Quality Report.

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

The Director of Nursing chairs the Trust's Data Quality Steering Group. The Group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation and that this is supported by appropriate polices or procedures to secure the quality of the data recorded and used for reporting. It is also tasked with the Trust has in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality.

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

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

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

Data use and reporting
Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Performance EMT and Trust Board, with KPIs set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues.

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

Review of effectiveness

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

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

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

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

As a result of an inspection visit to the Fieldhead site by the Care Quality Commission, the Trust was issued with two compliance actions in July 2013. Locations visited were Trinity 2, Newton Lodge and Bretton. The CQC found that overall patients were receiving a good level of service; however, there were some concerns regarding the design and layout of some of the hospital's seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). The CQC also identified some concern regarding how some patients' seclusions had been reviewed and continued. A detailed action plan was submitted to address the compliance issues, which was fully completed in June 2014. The CQC has yet to return to the Trust to review the compliance actions.

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

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

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

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

From April 2014 to January 2015, twelve internal audit reports were presented to the Audit Committee. Significant assurance was received for three reports and significant assurance with minor improvement opportunities given in six areas. Three reports were given partial assurance in relation to patients' property, bed management and data quality.

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

Three reviews are ongoing at the end of the year and are due to report to the Audit Committee in July 2015.

The Head of Internal Audit's overall opinion for 2014/15 is one of substantial assurance.

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business

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

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

Conclusion

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

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

Over the past year, the Trust has undergone significant change; however, it is my view that the system of internal control has remained robust and enabled change and risk to be managed effectively.

……

Steven Michael
Chief Executive
22 May 2015

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality account | 2014/15

Improve and be outstanding

With all of us in mind

A year at South West Yorkshire Partnership Foundation Trust…

We made more than

400,000
mental health contacts

600,000
community contacts

17,000
Learning disability contacts

85%
of our patients in mental health services would recommend us to friends and family

97%
of people were followed up within 7 days

98%
of our patients in community services would recommend us to friends and family

100%
compliance with the NHS Library Quality Assurance Framework 2014

We employ more than **4500** NHS staff

Contents

Part 1:
Chief Executive and Chair's Welcome

Welcome to our Quality Account report. Here we'll provide a flavour of our quality improvements and confirm our commitment to delivering high quality and safe care in the future. We'll set out:

Our approach to quality

Our priorities for 2015-16

Our performance against nationally mandated priorities

Our performance against quality priorities we've set for ourselves.

Listening to and acting on service user feedback continues to play a central role in the Trust's delivery of quality. Our established Customer Services function has been pivotal in delivering this throughout 2014-15, placing an increased emphasis on using individual experience to improve services. In addition, the Trust took part in the 15 steps challenge (developed by the NHS Institute for Development and Improvement) in 2014 and will do so again this year. The NHS Friends and Family Test (FFT) has been running at the Trust since October 2014, we've been committed to listening and acting on feedback from our patients for a number of years, so this has been a natural progression for us.

As demands for our services continue to increase we remain concerned about the speed at which people can access our services, particularly in secondary mental health care and child and adolescent mental health services (CAMHS). Our Transformation programmes are addressing these issues. For example, we have introduced a mental health liaison service into all our acute general hospitals which allows our nurses to provide early help when people are in distress.

Patient safety has been a particular focus throughout the year with our new patient safety strategy which brings together all our work in this area. This strategy is aligned to the national initiative, Sign up to Safety, through which we have pledged to reduce harm by up to 50% in these areas:

1. Falls
2. Medication omissions
3. Pressure ulcers
4. Prone restraint
5. Injuries following physical restraint

Along with other trusts across the country we continue to implement the actions identified during our work in 2013-14 around the Francis, Keogh and Berwick reports, which are the high profile reviews focused on quality and safety.

We've also recognised the implications of the Dalton review and the NHS Five Year Forward View (NHS England). We believe we're well-placed to respond to the direction indicated in the review; our services continue to be locally based and we recognise the importance of all partners working together for local benefit.

We continue to work to the standards set by the Care Quality Commission and share the regulator's aim that our service users are provided with safe, effective, compassionate, high-quality care. We've continued to challenge ourselves to meet the standards of quality and safety that people have a right to expect and have monitored ourselves closely through our own inspection programme of visits to teams.

Throughout the year we've also been reviewing the impact of the new Safer Staffing directive from NHS England which has required us to publish details of our inpatient staffing on a monthly basis. We've developed a new evidence based tool to reassess our staffing levels and check that they are set at the correct level. This is being trialled throughout the first part of 2015-16. We're pleased to report that our fill rates have stayed at a high level throughout the year as a result of strong shift management and further investment into nurse staffing in a number of key areas of pressure across the Trust.

Being honest, open and transparent is embedded within our trust's official values. This year has seen the introduction of the new Duty of Candour which requires health services to be more open in their response when they make mistakes. As a result, we've enhanced our notifications to people on a more formal basis when we make errors.

Throughout 2014-15 our Quality Improvement Strategy has driven our improvement plan to make change within the Trust and we have reviewed the quality in the services we deliver. In part three 'Our performance in 2014-15 you will find details of the progress we have made against each of our quality priories. This year has also seen a change in our management and leadership arrangements to support a culture of strong governance and quality. As a result, each service line (a group of services) now has a separate clinical lead, general manager and practice governance coach who can support the quality, clinical leadership and efficient use of resources in a way that is closer to patients.

We continue to review our cost improvement plans to understand the impact upon quality. Demands on our services are growing and this again places services under extra pressure. In spite of this, we've continued to improve, maintaining the critical balance between safe, high quality services and our ongoing financial responsibility. Examples of our achievements are discussed throughout the document and include achieving 90% of our Commissioning for Quality goals and winning national awards for our Creative Minds initiative.

Statement of assurance

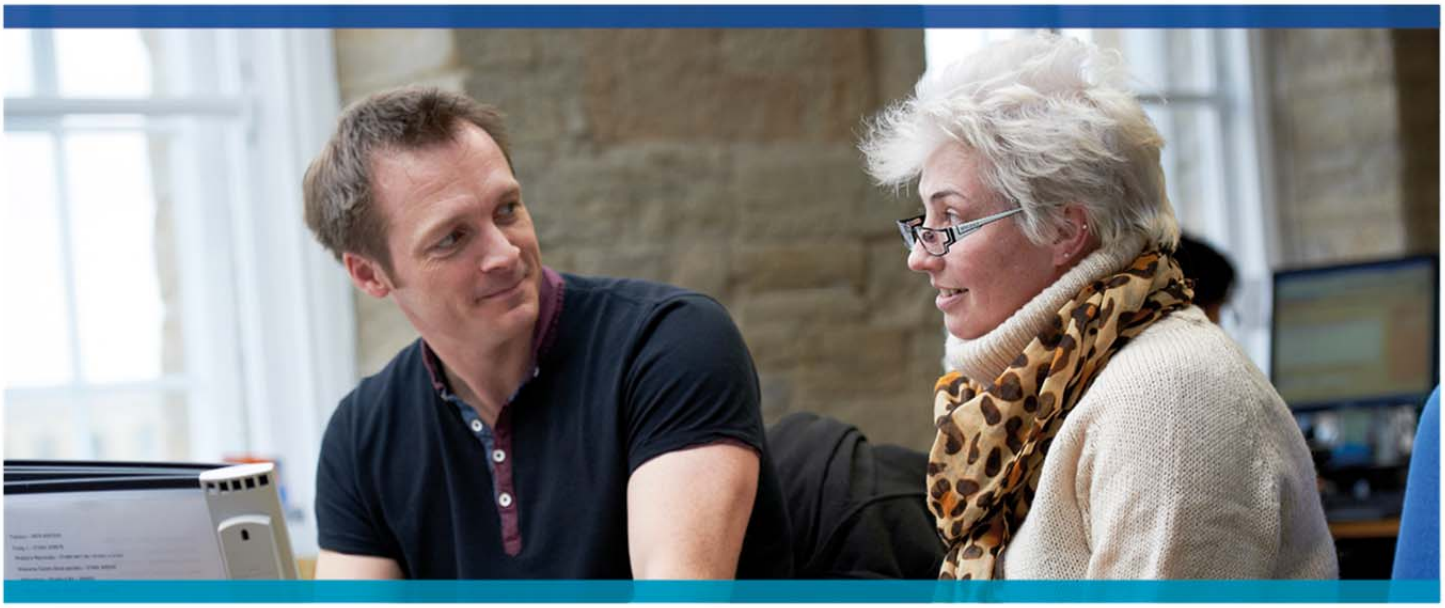
This quality account has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and Monitor, the independent regulator of foundation trusts. The board of directors has reviewed the quality account and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.

Date: 22 May 2015

Chief Executive:
Steven Michael OBE

Date: 22 May 2015

Chair:
Ian Black



Part 2:
Priorities for improvement and statements of assurance by the board

In part two of our Quality Account we'll outline our planned improvement priorities for 2015-16 and provide a series of statements of assurance from the board on mandated items, as detailed in the 'Detailed requirements for quality reports 2014-15' (www.gov.uk/monitor).

Part 2.1 – Priorities for improvement

Our Quality Improvement Strategy outlines our commitment and approach to quality and shows that quality is at the heart of what we do.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has consulted with stakeholders, through the Quality Account Survey, to inform our quality priorities for the coming year. This information, along with patient experience feedback, our Commissioning for Quality Improvement Scheme (2015-16) and our annual governance report information has determined our priorities for 2015-16. Against each of our quality priorities we've set ourselves measures of success. The measures are reviewed and refreshed each year to make sure we're adapting to both local and national intelligence, and progressing against our aim to '***improve and be outstanding'***.

Our quality improvement initiatives for 2015-16 continue to be organised under the headings of our seven quality priorities (as detailed below). Throughout 2014-15 we measured activity against each of these priorities and reported them to our Clinical Governance and Clinical Safety Committee. Our progress against these priorities can be found in 'Part 3 – Our Performance in 2014-15.

Although our quality priorities have remained consistent over the past three years, the quality initiative's we undertake against these priorities can change from year to year, which means we are not able to make a direct comparison of our performance against each priority each year, as we are not comparing 'like for like'.

Our Quality Priorities are:

Priority 1: Service users are central to what we do (Listen and act)

We want people who use our services to have a positive experience. We strive to listen and act on patient feedback to continually to improve this experience.

Priority 2: Timely access to services (Access)

We want to improve access times for people who are referred into our services so they get the right support from the right service at the right time.

Priority 3: Improve care and care planning (Care planning)

We believe that individualised personal care is essential to enable a person's recovery. Everybody should have an appropriate assessment of their needs and an individualised care plan that supports them in achieving their goals.

Priority 4: Improve recording keeping and data quality (Recording care)

We want to record each intervention in a timely manner. This is vital in providing safe, effective clinical care.

Priority 5: Improve transfers of care by working in partnership across the care pathway (Care pathways)

We want to support service users to move along the care pathway in a timely way. We also want services to communicate effectively to prevent duplication or gaps in service provision.

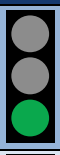
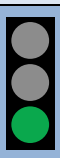
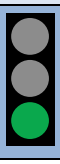
Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake their duties (Fit and well to care)

We know that our staff are our most valuable asset. We are committed to valuing our workforce and know that staff who feel valued are more likely to provide excellent care.

Priority 7: Improve the safety of our service users, carers, staff and visitors (Safety)

We have a duty of care to our service users, carers, staff and visitors to protect them from harm. We want to deliver safe, effective and appropriate treatment, as well as safe buildings in which to work and receive care.

Our quality priorities – summary of performance in 2014-15

Quality priority	Progress	Quality priority	Progress
Listen and act		Care pathways	
Access		Fit and well to care	
Care planning		Safety	
Recording care		**Key:** **Green: 75% or more of KPIs achieved** **Amber: 65-74% of KPIs achieved** **Red: Less than 65% of KPIs achieved**	

Quality Risks

To maintain rigour around our progress, the Trust put in place challenging performance indicators against each priority. It has maintained a good standard of performance against the majority of the indicators. Overall we have totally achieved 63% of the key performance indicators we identified in 2014-15, and in 20% of cases we were within ten percent of achieving the goal. We continue to have high performance in the areas of listening and acting on patient feedback, working across care pathways and patient safety. Details of our achievements are discussed in Part 3 'our performance in 2014-15. There are some areas where there has been consistent underperformance against targets in 2014-15:

Access:

- Underachievement against the 90% target for face-to-face contact within 14 days of referral for people with non-acute mental health problems in Calderdale, Kirklees and Wakefield.
- Underachievement against the 100% target of Barnsley CAMHS patients seen within 5 weeks of referral

Improve care planning:

- Underachievement against the 90% target regarding adherence to cluster reviews in mental health
- Underachievement of our mental health clustering assessments

Improve recording and evaluation of care:

- Concerns remain with the quality of clinical record keeping and data quality.

Staff professionally, physically and mentally fit to do their duties

- Underachievement against the 4% sickness target (however the Trust remains compliant with the national 5% target)
- Underachievement of internal goals for staff friends and family test

For each quality improvement area there will be clear organisational leadership processes so the Trust can monitor and review progress in each area.

A quality group has been set up with cross-organisational multi-professional quality leader representation. The group will be responsible for implementation and ongoing monitoring of the quality improvement action plan.

We will continue to use our annual clinical audit programme to make sure improvements are implemented and sustained. Sustainability is also supported by a programme of reporting to Trust Board regarding:

- Quality performance
- Compliance with CQC regulatory requirements
- Compliance with the terms of our foundation trust licence
- Assessment against national and local targets including CQUINs.

The Trust Board has recognised that the organisational focus on transformation activity may lead to a lack of attention to quality within the day-to-day delivery of services. We are managing this risk through:

- Regular monitoring and reporting against quality indicators to EMT and the board
- Clear accountabilities for both operational delivery and transformational change.

The Trust continues to operate a robust quality impact assessment process that is applied to all cost improvement programme changes before implementation. This rigorous challenge process helps safeguard quality and includes review at several organisational levels.

Quality priorities 2015-16

Priority 1: Service users are central to what we do				
Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
The Trust will demonstrate that we have listened and acted on patient feedback.	Act on the feedback we receive from the Friends & Family Test and other patient experience surveys.	Forensic service Learning disability services (Trust wide) Barnsley Community Service teams e.g. District Nursing Service CAMHS (Trust wide)	We will measure the percentage of people who are extremely likely/ likely to recommend the service to their friends and family. We will review the actions taken in response to patient experience feedback.	Forensic 70% Learning disabilities 85% District nursing services 90% CAMHS 75%
Priority 2: Timely access to services				
Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
Improve the access times for people who are referred into our services to ensure the right support from the right service at	In line with service transformation the Trust will continue to review and develop access to our services by	Mental health (adult & older peoples services trust wide)	Improve access for people experiencing non-acute mental health problems we will see people within 14 days of referral.	90%

the right time.	implementation of the mental health acute and community transformation model.	Implementation of single point of access (SPA) across all mental health services for adults and older people.	Quarterly monitoring of progress via the Transformation Programme Board.	Quarterly report
		Implementation of the Mental health crisis concordat	Quarterly monitoring of progress via the project implementation team	Quarterly report
		Care navigation and tele-health services	Quarterly monitoring via Barnsley BDU Quality Performance & Finance meeting	Q1 establish baseline Q2, Q3 & Q4 = 100% of new referrals into the service areas will be allocated a score
	The Trust will continue to review and improve access to our CAMHS services.	CAMHS services in Barnsley and Calderdale/ Kirklees	Monthly reporting via the CAMHS Quality and Performance Dashboard (from June 2015)	To achieve goals for access to CAMHS as agreed with our commissioners.

Priority 3: Improve care and care planning (care, care planning and evaluation)

Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
Improve the timeliness of assessment of need and provision of appropriate care.	Audit the number of people who have had an assessment of their needs and been allocated to a care pathway within 8 weeks of referral.	Mental health (adult and OPS) in Calderdale, Kirklees & Wakefield	A care pathway has been identified within 2 months for 98% (aggregate) of 'eligible' initial referral assessments.	98%
	Timely review of need.		Adherence to care pathway review periods.	80%
	Monitor the quality of care plans: Service users subject to the Care Programme Approach will have a care plan that is individualised, underpinned by recovery principles and focused on staying well		Audit using a predetermined audit tool developed by SWYPFT and CCGs	80% of case notes audited will contain the relevant evidence
	Involve secure service users in a process of collaborative risk assessment and	Forensic services	Completion of a predetermined evidence schedule	Report to commissioners.

	management. Use of Outcome Measures: Measure the use of clinically relevant outcome tools across the learning disability service. Use the outcome tools to contribute to monitoring the effectiveness of treatments and interventions.	Learning disability services in Calderdale, Kirklees & Wakefield	Two measures will be monitored: A – percentage of service users for whom an outcome has been achieved and reviewed B – percentage of improvement identified at discharge or review.	Part A - Q1= 50%, Q2 = 60%, Q3 = 70%, Q4 = 80% Part B - 50% of service users to achieve improvement at review or discharge

Priority 4: Improve record keeping and data quality

Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
Ensure each intervention is accurately recorded in a timely manner to support effective care delivery.	Implement clinical record keeping audit action plans. Monitor reports on clinical performance data. Put in place clinical performance data action plans.	Acute and community mental health services Community & well-being services CAMHS Forensic services Learning disability services	Progress against clinical record keeping action plans will be monitored via BDU governance groups. Progress on performance data will be monitored through local BDU performance meetings and reported quarterly into the data quality strategic group. Monitoring of uptake of data quality e learning package	Quarterly Clinical audit report Month on month improvement in number of people who have completed the e-learning training.
	Monitor compliance with Mental Health Act documentation.	Acute and community mental health services Forensic services Learning disability services	Audit of compliance. Progress against action plans will be monitored via BDU governance groups	Quarterly progress report.

Priority 5: Improve transfers of care by working in partnership across the care pathway

Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
We want people to be transferred to the most appropriate service and team in a safe and effective way with no delays between services, and then move along the care pathway in a timely way. We also want services to communicate effectively to prevent duplication or gaps in service provision.	Implementation of our Minimising Delays Transfers of Care (DToC)-Operating Procedure.	All trust bed-based services.	Monitor delayed transfers of care performance figures. Audit of standing operating procedure implementation	< 7.5
	Review our transition protocols from CAMHSs to working age adults services.	CAMHS & mental health adult services (trust wide).	CAMHS governance meeting will monitor progress	Quarterly report
	Communication with general practitioners. Patients on CPA with a diagnosis of psychosis should have either an updated CPA care plan or a comprehensive discharge summary shared with the GP	Calderdale, Kirklees & Wakefield Mental Health (Adult & OPS)	Audit of communications to be completed.	90%
	Implementation of the Care Programme Approach framework in CAMHS services	CAMHS	Audit of implementation in Q4	Quarterly reports to governance group

Priority 6: Ensure that our staff are professionally, physically and mentally fit to do their duties

Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
Our staff are our most valuable asset. By ensuring our staff feel valued and fit and well to care we know they are more likely to provide consistently excellent care.	The Trust will demonstrate that we have listened and acted on staff feedback.	Trust wide	We will measure the percentage of staff who are extremely likely/ likely to recommend the service to their friends and family as a place to work and as a place to receive care and treatment. We will review the actions taken in response to patient experience feedback. We will measure organisational performance in the well- being at work	80% Evidence of actions taken against staff feedback

	Development of Trust wide clinical supervision audit.	Trust wide	survey. Audit to be completed.	Implementation of recommendations of audit.
Priority 7: Improve the safety of our service users, carers, staff and visitors				
Quality Improvement Goal 15-16	What we will do	Area applicable to	How progress will be measured	Standards/ Goal
We want to make sure the people who work with us and visit us are safe from harm.	Implementation of mental health safety thermometer. Implementation of action from 'Sign up to safety' campaign	Mental health (adult & OPS) in Calderdale, Kirklees & Wakefield	Monthly reporting and analysis of data for all relevant patients and settings using the NHS mental health safety thermometer in quarters 3 & 4	Upload of monthly data
	Forensic services: Cardio metabolic assessment and treatment for patients with psychoses	Forensic services	At Quarter 4 (15-16) the audit results will show that, for 90% of patients audited during the period (inpatients), the provider will have undertaken an assessment of key cardio metabolic parameters	90%
	Learning Disability Cancer screening	Barnsley BDU		30% = Q1 report = 10%, Q2, Q3 & Q4 = achievement of trajectory = up to 30% per quarter (10%/quarter achieved)

The measures identified in the Quality Priorities 2015-16 – (above) will be reported and monitored in the following ways throughout the year:

1. Monthly reporting in the Quality & Performance Report to Executive Management Team performance meetings
2. A 'Quality Account Report' will be produced on a bi monthly basis for the Clinical Governance and Clinical Safety Committee.
3. To Clinical Commissioning Groups via Quality Board meetings.

Part 2.2 – Statements of assurance from the board

Review of services

During 2014-15 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 117 relevant health services. South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 117 (100%) of these services.

The income generated by the relevant health services reviewed in 2014-15 represents 100 percent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2014-2015.

Participation in clinical audit

During 2014-2015 ten national clinical audits and one national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2014-15 South West Yorkshire Partnership NHS Foundation Trust participated in 8/10 (80%) of the national clinical audits and 1/1 (100%) of the national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2014-2015 are as follows:

National Clinical Audits SWYPFT was eligible to participate in during 2014-2015	1) POMH Topic 4b: Prescribing anti-dementia drugs 2) POMH Topic 10c: Use of antipsychotic medication in CAMHS 3) POMH 14a: Prescribing for substance misuse: Alcohol detoxification 4) POMH 12b: Prescribing for people with personality disorder 5) POMH 6d: Assessment of side effects of depot antipsychotics* 6) POMH 9c: Antipsychotic prescribing for people with a learning disability 7) National Audit of Schizophrenia 8) National audit of chronic obstructive pulmonary disease (COPD) 9) National audit of intermediate care (NAIC) 10) Sentinel Stroke National Audit Programme (SSNAP)*
National Confidential Inquiries SWYPFT was eligible to participate in 2014-15	11) National Confidential Inquiry into Suicide and Homicide by people with mental illness

*Prescribing Observatory Mental Health (POMH) 6d: Assessment of side effects of depot antipsychotics. POMH postponed this audit due to overlap with and commitment to the national Mental Health CQUIN 2014-2015 (indicator 1) cardio metabolic assessment for patients with schizophrenia.

*Sentinel Stroke National Audit (SSNAP) – the Trust is registered for this project but didn't participate as the audit has a staffing resource issue. A business case has been developed and is with the commissioners for their funding decision.

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in during 2014-2015 are as follows:

National Clinical Audits that SWYPFT participated in 2014-2015	1) POMH Topic 4b: Prescribing anti-dementia drugs 2) POMH Topic 10c: Use of antipsychotic medication in CAMHS 3) POMH 14a: Prescribing for substance misuse: Alcohol detoxification 4) POMH 12b: Prescribing for people with personality disorder 5) POMH 9c: Antipsychotic prescribing for people with a learning disability 6) National Audit of Schizophrenia 7) National audit of chronic obstructive pulmonary disease (COPD) 8) National audit of intermediate care (NAIC)
National Confidential Inquiries 2014-15	9) National Confidential Inquiry into Suicide and Homicide by people with mental illness

National clinical audit programme 2014-2015

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2014-2015, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

The percentage of registered cases required by the terms of that audit is not specified. This is because the Prescribing Observatory for Mental Health (POMH) audits do not specify a minimum number in their sampling framework criteria.

Audit title	Number of cases submitted	Actions
POMH Topic 4b: Prescribing anti-dementia drugs	Data collection November 2013. 183 cases from 4 BDUs submitted. Report received March 2014.	Wakefield BDU uses a pathway in which the GP completes the initial screening, including physical examination, prior to starting anti-dementia medication. This is audited in each two-year Memory Services National Accreditation Programme (MSNAP) accreditation cycle. We're waiting for our accreditation outcome.
POMH Topic 10c: Use of antipsychotic medication in CAMHS	Data collection January 2014. 56 cases from 3 teams submitted. Report received August 2014.	Our CAMHS consultant psychiatrists are leading on implementing the action plan. Actions agreed: (1) The lack of equipment in clinics, particularly in bespoke clinics, is being reviewed by management. (2) More resources, e.g. nurse and onsite phlebotomist, will make sure blood, height and weight are monitored for service users on antipsychotics. (3) We will improve documentation in both electronic or paper notes about side effects.
POMH 14a: Prescribing for substance misuse: Alcohol detoxification (baseline)	Data collection March/April 2014. 22 cases from 4 teams were submitted. Report received August 2014.	Brief summary results were circulated to BDUs for development and implementation of action plans. These were presented to Calderdale & Kirklees medical audit meeting and the following actions agreed; (1) All clinicians should be aware of the risk of Wernicke's encephalopathy and look for this proactively. (2) We will write to the medical director about amendments to the physical examination proforma; (3) Advice about looking for Wernicke's encephalopathy will be included in the junior doctor induction.
POMH 12b: Prescribing for people with personality disorder (re-audit)	Data collection June/July 2014; 136 records submitted from 7 teams. Report received Dec 2014.	Audit results were shared via a linked network of practitioners in Calderdale and Kirklees BDU with an interest in personality disorder. Practitioners to (1) Focus on reasons for prescribing psychotropic medications in personality disorder; (2) Make sure prescriptions are only for a short time. (3)Tell primary care that medication is not to be on repeat prescription; (4) Ensure timely review of any medication prescribed for personality disorders.
National audit of intermediate care (NAIC)	Data collection May/July 2014. Minimum sample sizes submitted from 3 teams. Report received Nov 2014.	A new service specification starts in April 2015 and therefore the service is being restructured to implement this. Registered for re-audit from April 2015.
National audit of schizophrenia	Data collection August-November 2013. Audit of practice 82/100 (82%) from 4 BDUs submitted. Service user survey 60/200 (30%) response. Carer survey 11/200 (6%) response.	The 'NAS2 Action Working Group' has developed an action plan which was signed off at the Drug and Therapeutic Sub-committee in February 2015. The plan has been shared with each BDU to devise their own locally relevant action plan.
POMH 9c: Antipsychotic prescribing for people with a learning disability (re-audit)	Data collection February/ March 2015. 169 cases submitted from 5 teams. Report due July 2015.	Not applicable
National audit of chronic obstructive pulmonary disease (COPD) (baseline)	Data collection Jan-Apr 2015.	Not applicable

The reports of 6 national clinical audits were reviewed by the provider in 2014-2015 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Each clinical audit has a project lead in the governance group. This lead is responsible for presenting the audit results to their business delivery unit. Areas of concern or high risk are escalated to the deputy district director for immediate action.

The members of the governance group or another lead will action the plan against the audit recommendations.

Implementation of the action plan is monitored by the Clinical Governance Support Team and reported to the Clinical Audit Strategic Group.

Outcomes from clinical audits are reported to the Clinical Governance and Clinical Safety Committee.

National confidential inquiry (NCI) 2014-2015

Title	Number of cases submitted	Commentary
National Confidential Inquiry into Suicide and Homicide by people with mental illness	38 / 95%	2 cases received **30th March 2015** have not been returned within the reporting period (1st April 2014- 31st March 2015) which is to be expected given the timeframe

Local clinical audit

During 2014-2015 the Clinical Audit and Practice Evaluation (CAPE) prioritised plan had a total of 157 projects listed. The reports of 52 local clinical audits / practice evaluations were reviewed by the provider in 2014-2015 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Each clinical audit has a project lead in the governance group. This lead is responsible for presenting the audit results to their business delivery unit, Areas of concern or high risk are escalated to the deputy district director for immediate action.

The members of the governance group or another lead will action the plan against the recommendations.

Implementation of the action plan is monitored by the Clinical Governance Support Team and reported to the Clinical Audit Strategic Group.

Outcomes from audits are reported to the Clinical Governance and Clinical Safety Committee.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by SWYPFT in 2014-15 that were recruited during that period to participate in research approved by a research ethics committee 301.

During this period the Trust was involved in conducting fifty eight clinical research studies in mental health, learning disabilities and community services and the involvement in large-scale research projects that the National Institute for Health Research (NIHR) supported was thirty one. Two hundred and six members of staff participated as researchers in studies approved by an ethics committee with 17 of these in the role of Principal Investigator.

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of income in 2014-15 was conditional upon achieving quality improvement and innovation goals agreed between South West Yorkshire Partnership NHS Foundation Trust and any person or body we entered into contract, agreement or arrangement with for the provision of relevant health services, through Commissioning for Quality and Innovation Payments Framework.

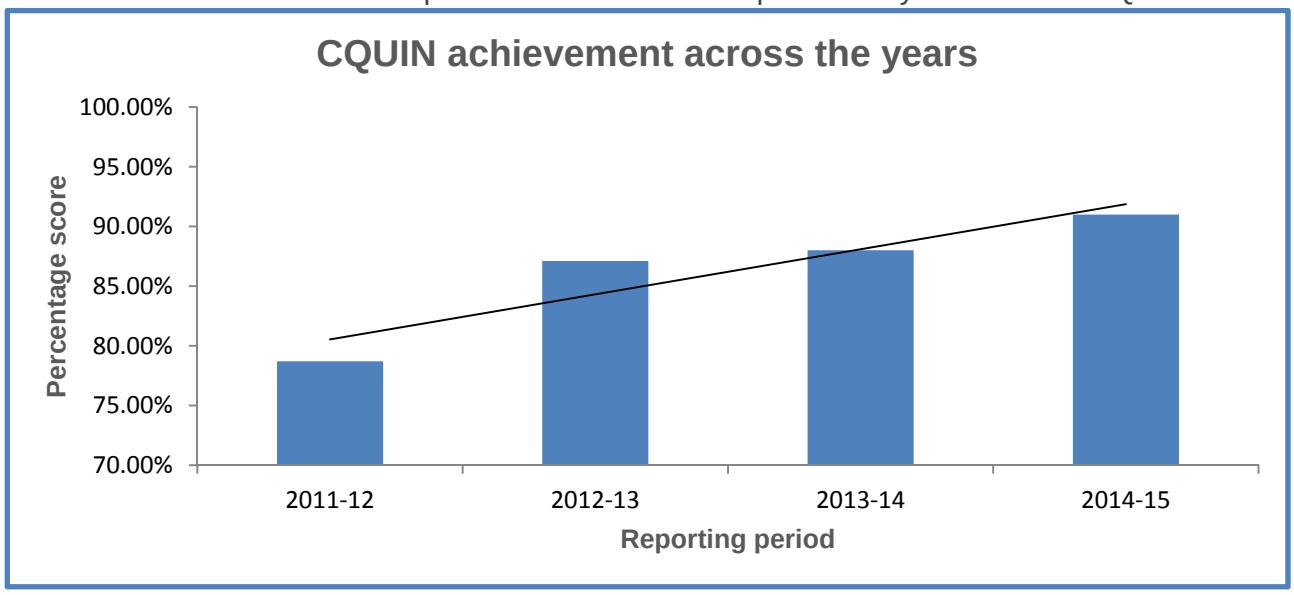
Further details of the agreed goals for 2014-15 and for the following 12 month period are available electronically at www.swyt.nhs.uk

The Trust met 90% of its quality innovation goals in 2014-15

An overall total of £4,640,266 was available for CQUIN to SWYPFT in 2014-15 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,498,930 (90%) is expected to be received for the associated payment.

By comparison an overall total of £4,659,979 was available for CQUIN to SWYPFT in 2013-14 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,087,704 (88%) was be received for the associated payment.

The chart below shows an upwards trend over the past four years in our CQUIN achievements



Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Wakefield, Kirklees, Calderdale	Mental health and learning disabilities	Safety thermometer	487,962	100%
		Improve access	188,463	92%
		Learning disabilities	406,905	97%
		Improving physical healthcare	153,883	100%
		Patient experience	459,657	76%
		Friends & family test	154,113	100%
		Prescribing	459,570	80%
		Total	**2,310,553**	**90%**
Secure services	Secure services	NHS safety thermometer	57,147	100%
		Improving physical healthcare	57,148	100%
		Collaborative risk assessments	200,018	100%
		Supporting carer involvement	100,009	100%
		Needs formulation at transition	100,009	100%
		Quality dashboard	57,148	100%
		Total	**571,479**	**100%**
Barnsley	Mental health, community services and learning disabilities	Friends and family test	107,793	100%
		NHS safety thermometer	107,793	100%
		Improving physical healthcare	107,793	66%
		Pressure ulcers	258,704	50%
		Antimicrobials	194,028	100%
		Learning disability cancer screening	323,379	92%
		Dementia	388,056	100%
		High performing teams	129,352	100%
		Health Visiting	99,764	100%
		Weight management programme	9,750	92%
		Total	**1,758,234**	**89%**

Care Quality Commission (CQC)

South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and Screening Procedures

Family Planning

Maternity and Midwifery Services

Nursing Care

Treatment of disease, disorder or injury

There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on at or from.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2014-15.

South West Yorkshire Partnership NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2014-15:

CQC thematic review of mental health crisis care. The focus was on the ways that a person may come into contact with services whilst in crisis. The local inspection occurred during February 2015 and the report has yet to be received. Any required action will be determined following receipt of the report.

NHS Number and General Medical Practice Code Validity

Records that included the patient's valid NHS number 2014-15:

99.8% for admitted patient care

100% for outpatient care

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2014-15 to the Secondary Uses service for inclusion in the Hospital Episode statistics that are included in the latest published data.

The percentage of records in the latest published data that included the patient's valid NHS number was:

99.8% for admitted patient care

100% for outpatient care

N/A for accident and emergency care

The percentage of records in the latest published data that included the patient's valid General Medical Practice Code was:

99.1% for admitted patient care

98.8% for outpatient care

N/A for accident and emergency care.

Information Governance Toolkit attainment

South West Yorkshire Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2014-15 is 66% and is graded green

Clinical Coding accuracy

Our latest audit of clinical coding showed 91.2% of primary diagnoses and 97.2% of primary procedures were coded accurately.

South West Yorkshire Partnership NHS Foundation Trust has not been subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

However, an external audit of the clinical coding of diagnoses and procedures for inpatients, by approved auditors, is done annually to make sure the Trust is keeping up to date with and accurately following the national rules for clinical coding. The audit for 2014-15 randomly selected 80 episodes of inpatient care; 736 recorded diagnoses and procedures were audited. 91.2% of primary diagnoses and 97.2% of primary procedures in the audit were found to be accurately coded.

Quality of data

Improving data quality remains one of the Trust's key strategic priorities. There was continued focus in 2014-15 on improving the quality of clinical record keeping. This underpins the delivery of safe effective care and assures the Executive Management Team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Trust will take the following action in 2015-16 to further improve data quality:

Bringing clarity to quality	We will continue to improve the training, guidance and support available to help staff and services understand and improve data quality.
Measuring quality	We will continue to develop a wide range of team, service line, BDU and Trust level operational and performance reports. Service line reporting and electronic dashboards will include key performance indicators. This will enable users to look at performance at team, service line, BDU and Trust levels. Internal and external benchmarking will be used.
Publishing quality	The Trust will continue to publish its data to the Secondary Uses Service, Monitor, CQC, the Department of Health, Commissioner, partners and the Members' Council.
Partnership for quality	We'll continue to work with partner organisations to make sure we meet our respective quality and performance requirements and that duplication of data collection and inputting is minimised.
Leadership for quality	The Data Quality Steering Group will oversee the development and delivery of the 2015-16 data quality improvement programme and will provide progress updates to the executive management team. BDUs will develop and deliver individual BDU-level improvement plans.
Innovation for quality	We'll continue to optimise our clinical information systems (RiO and SystmOne) and exploit new technology to make these systems easy to access and use.
Safeguarding quality	The Trust's executive management team will continue to review key performance information and take action where data quality issues arise.

Part 2.3 – Reporting against core indicators

Patients on Care Programme Approach who were followed up within seven days

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data Goal = 95%					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions	SWYPFT 2013-14	92.11%	93.81%	91.92%	95.18%	93.23%
		SWYPFT 2014-15	96.78%	96.19%	96.33%	98.02%	96.86%
		NHS England (NHSE) data 2014-15	97%	97.3%	97.3%	97.2%	-
		NHSE provider lowest performance (2014-15)	93.0%	91.5%	90.0%	93.1%	-
		NHSE provider highest performance 2014-15	100%	100%	100%	100%	-

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the clinical record

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training

Data is clinically validated before it is submitted to the Health and Social Care Information Centre

Performance data is reviewed monthly by the Executive Management Team and the Trust Board

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

A Data Quality Group sponsored and chaired by the Director of Nursing, Clinical Governance and Safety, that meets quarterly to focus on the quality of clinical data. Each Business Delivery Unit has developed an action plan to improve the quality of their clinical data.

Each business delivery unit is provided with performance and quality reports on the monthly basis. The senior management team scrutinize the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	2: Enhancing quality of life for people with long-term conditions	SWYPFT 2013-14	99.7%	99.5%	99.7%	99.2%	99.52%
		SWYPFT 2014-15	99.54%	98.55%	100%	99.15%	99.31%
		NHS England (NHSE) data 2014-15	98.0%	98.5%	97.8%	98.1%	-
		NHSE provider lowest performance 2014-15	33.3%	93.0%	73.0%	59.5%	-
		NHSE provider highest performance 2014-15	100%	100%	100%	100%	-

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the clinical record

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training

We have an emergency code 25 that staff use for all gate kept admissions - this information can be extracted directly from the electronic record system

Data is clinically validated before it is submitted to the Health and Social Care Information Centre

Performance data is reviewed monthly by the Executive Management team and the Trust Board

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

A Data Quality Group sponsored and chaired by the Director of Nursing, Clinical Governance and Safety, that meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.

We undertake a weekly audit of our gate kept admissions to validate the gate keeping function.

Each business delivery unit is provided with performance and quality reports on the monthly basis. The senior management team scrutinize the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

Readmission rates

This information is not made available to SWYPFT by the Health and Social Care Information Centre. The HSCIC monitor re-admissions within 30 days, in SWYPFT we monitor re-admissions within 28 days and hence the data is not comparable.

Indicator	NHS Outcomes Framework Domain	SWYPFT data			
		2011-12	2012-13	2013-14	2014-15
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	3: Helping people to recover from episodes of ill health or following injury	6.15%	6.86%	7.02%	8.7%

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons

91.3% of people were not readmitted.

Our transformation work is, in part, focused on developing our care pathways to help reduce the number of readmissions to hospital

This information is taken from the clinical record

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training

Data is clinically validated before it is submitted to the Health and Social Care Information Centre

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- A Data Quality Group sponsored and chaired by the Director of Nursing, Clinical Governance and Safety, that meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data
- Each business delivery unit is provided with performance and quality reports on the monthly basis. The senior management team scrutinize the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

Staff Experience – staff survey 2014

Indicator	NHS Outcomes Framework Domain	2012 (score out of 5)	2013	2014	2014 National average
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	4: Ensuring that people have a positive experience of care	3.72	3.75	3.6	3.57

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons it was taken from the national staff survey, which uses approved survey contractors, external to the organisation and the information is provided anonymously.

The South West Yorkshire Partnership NHS Foundation Trust will take the following actions to improve our performance and therefore the quality of its services:

Continue to undertake our internal well-being at work survey on a six monthly basis which provides us with timely information from a broader range of staff compared with the national staff survey.

The Well Being in Partnership group has developed an action plan to oversee the improvement work needed.

The action plan progress will be reported into Executive Management Team, Trust Board and Members' Council, Trust's Partnership Forum (staff side and partners) and to our Quality Boards.

Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

Indicator	NHS Outcomes Framework Domain	SWYPFT 2014 Score (out of 10)	National 2014score	
			Highest trust score	Lowest trust score
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2: Enhancing quality of life for people with long-term conditions 4: Ensuring that people have a positive experience of care	7.9	8.4	7.3
		SWYPFT 2013 score	**National 2013 score**	
			Highest trust score	**Lowest trust score**
		8.6	9.0	8.0

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons, it was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and the information is provided anonymously.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services: triangulating this information with other sources of patient and staff experience feedback in order that we can successfully focus our action.

The number and percentage of such patient safety incidents that resulted in severe harm or death

Indicator		NHS Outcomes Framework Domain			
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.		5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Period	**Number of patient safety incidents uploaded**	**Severe (no)**	**Severe (%)**	**Death (no)**	**Death (%)**
14-15 Q1	1205	3	0.25%	18	1.50%
14-15 Q2	1214	5	0.41%	12	0.99%
14-15 Q3	1071	1	0.10%	10	0.93%
14-15 Q4	1045	5	0.48%	11	1.06%
Totals:	**4535**	**14**	**0.30%**	**51**	**1.10%**

The Trust introduced the ability to capture the actual degree of harm of a patient safety incident in January 2014. This was introduced because prior to this, only the incident severity could be used, which was based on both actual and potential harm. This did not accurately reflect the degree of harm defined by the Patient Safety Agency. Incident severity continues to be the primary method for grading incidents in the Trust.

There is a natural delay in uploading some patient safety incidents to the National Reporting and Learning System (NRLS). Incidents are only uploaded to the NRLS when they have been through the management review and governance processes. This ensures accuracy of data. Incidents are exported when these reviews have been completed. Those incidents that have not yet been uploaded have been reviewed and the overall figure is likely to increase slightly, however none of the incidents relate to severe harm or patient safety related deaths.

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reason:

In 2014-15, the Trust reported a total of 65 severe harm and patient safety death incidents compared to 97 incidents in 2013-14. It should be noted that the figure for 2013-14 was primarily based on the incident severity, rather than the degree of harm, as this was only introduced in Quarter 4 of 2013-14.

Although this is a reduction, it is difficult to compare annual figures, as they are not based on the same criteria. Clarity on the degree of harm of reportable incidents has continued to develop through 2014-15, such as on the degree of harm of different grades of pressure ulcers; for example, grade 3 pressure ulcers are classed as moderate degree of harm, grade 4 pressure ulcers as severe degree of harm.

We have also identified that incidents involving the actual or apparent suicide of patients who have been discharged from services (where last contact was in the last 12 months) do not need to be uploaded to the NRLS, unless the death was caused by a patient safety issue. These incidents had

been routinely uploaded to the NRLS system. This has been corrected from October 2014 onwards, which is evident in the figures for Quarters 3 and 4.

In May 2014, the Trust experienced a cluster of serious incidents resulting in deaths which is revealed in the Quarter 1 figures. These incidents have been reviewed, but no pattern or trends were identified.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following action in respect of the number and percentage of such patient safety incidents that resulted in severe harm or death:

- Nationally, it is believed that organisations that report more incidents usually have a better and more effective safety culture, with which we agree. If we understand what our incidents are, we can learn and improve our services. Each of our BDU's have a systematic way for reviewing learning from their incidents.
- A trust wide Patient Safety Clinical Reference Group coordinate trust wide learning of lessons learnt from incidents
- We will implement actions from the mental health safety thermometer programme and 'sign up to safety' campaign.

External audit of mandated and local indicators

As part of the Quality account report external assurance process, the auditors are required to undertake substantive sample testing on two mandated performance indicators (as described in the Risk Assessment Framework) and one locally selected indicator (to include, but not necessarily be limited to, an evaluation of the key processes and controls for managing and reporting the indicators and sample testing of the data used to calculate the indicator back to supporting documentation).

The **mandated items** selected by the Trust for this process were:

1. The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

   Please refer to page 22 for information on this measure.

2. Delayed transfers of Care (DTOC): the percentage of people who were occupying a hospital bed when they were ready to be discharged.

   Figures reported to Monitor, using the Risk Assessment Framework definition are as follows:

2014-15	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DTOC figures	4%	4.13%	4.59%	3.19%

The ‘Detailed guidance for external assurance on the quality reports 2014-15’ also requires trusts to calculate the DTOC figures using the following definition –

Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly Situation Report figures is used as the numerator and the denominator being the average number of occupied beds. The DTOC figure using this calculation are presented below. Please note: Whist there was a requirement for this DTOC calculation to be stated, it ***was not subject to external audit.***

2014-15	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DTOC figures	4.17%	3.78%	4.63%	2.85%

The **local item** selected by the Trust for this process was the number of pressure ulcer assessments that were undertaken by the second contact with the service. The following definition, the number of episodes of care that commence on or after 1 April 2014, who have a Waterlow Assessment with a date not earlier than that of 28 days before the commencement of the episode of care and the date of the second point of clinically relevant contact with a member of the home care team, was used to calculate our percentage figure, which can be found on the table below.

	Referral Month											
Valid	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Grand Total**
No	118	147	137	121	110	110	116	112	104	116	100	1291
Yes	144	130	124	130	109	167	190	142	144	175	166	1621
Grand Total	**262**	**277**	**261**	**251**	**219**	**277**	**306**	**254**	**248**	**291**	**266**	**2912**
	54.96 %	46.93 %	47.51 %	51.79 %	49.77 %	60.29 %	62.09 %	55.91 %	58.06 %	60.14 %	62.41 %	55.67 %

External Accreditation

External Accreditation	Comment
Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMs)	We have 2 adult mental health wards accredited with this programme
Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMs) - PICU	Both of our PICU units are accredited with this programme
Royal College of Psychiatrists ECT Service Accreditation	Both of our ECT suites are accredited with this programme
Royal College of Psychiatrists Memory Service National Accreditation programme	3 of our services are accredited with this programme
Royal College of Psychiatrists Forensic Mental Health Services (Quality Network)	Our Forensic service are members of the Quality Improvement Network

Customer Service Excellence Award	We were one of the first and few trusts nationally to be awarded the Customer Service Excellence award
Library Services Accreditation	We achieved 100% in the National Library Service Accreditation
University of Leeds: associated teaching trust status	Status in place for 5 years

Section 3:
Our Performance in 2014-15

In this section you'll find more information about the ***quality of our services***. In 2014-15 we set ourselves a set of challenging measures which in some cases were higher than the goals set by our commissioners. We'll take you through these measures and the work we did to improve the quality of our care.

Our quality improvement initiatives for 2015-16 continue to be organised under the headings of our seven quality priorities. Throughout 2014-15 we measured activity against each of these priorities and reported them to our Clinical Governance and Clinical Safety Committee and local commissioning groups.

Although our quality priorities have remained consistent over the past three years, the quality initiative's we undertake against these priorities in some cases does change from year to year, which means in some cases we are not able to make a direct comparison of our performance against each priority each year, as we are not comparing 'like for like'. Where we are able to make comparisons across the years we have done so. If comparable data is not present this is because we do not have the information to make the comparison. We make these changes to continually strive to improve the quality of our care. In 2014-15 we set ourselves a set of challenging measures to achieve. In some cases these measures were higher than the goals set by our commissioners.

Our seven quality priorities for 2014-15 are underpinned by a number of performance indicators. These include some current Key Performance Indicators and also Commissioning for Quality and Innovation goals (CQUIN). Note: the figures/ratings used in the Quality Account don't exactly correlate with achievement of CQUIN goals set by commissioners - this is because, for the Quality Account, a rounded average is taken across Business Delivery Units (BDU) and care groups rather than split for each care group and BDU. For a full list of performance indicators please refer to the table on pages 31 to 33.

Our Trust provides a wide range of services across a number of communities. These services are commissioned from two separate commissioning groups, i.e. Barnsley area and Calderdale, Kirklees and Wakefield area (C/K/W – 1 group). As commissioners are working for different communities the goals for each area can differ. However, as an organisation, SWYPFT ensures that a consistent quality threshold is applied across all services.

Quality Account 2014 – 2015

The 7 specified quality priorities for 14-15 are underpinned by a number of identified performance indicators including some current key performance measures and CQUIN targets.
Note: figures/ratings used do not exactly correlate with achievement of CQUIN targets set by commissioners - this is because for the Quality Account a rounded average is taken across BDUs and care groups rather than split down into target achievement in each care group and BDU.

Quality Priority	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
Quality Priority 1: To continue to listen to our service users and carers and act on their feedback	% people (inpatient mental health -CKW) rating care as excellent or good	90%	Quarterly	91%			87%			85%			85%			
	% of people in CAMHs service rating care as excellent or good.	70%	Quarterly from Q3							73%			70%			
	% of people in Long Term Conditions who are extremely likely/likely to recommend the service to their Friends & Family	90%	Bi annually	97%						97%						
	Benchmarking of elements of Triangle of care across all inpatient services	100%	Annual													
	Friends & Family Test: percentage of scores recommending our services as either likely or extremely likely:	80%	Quarterly from Q3				**Mental Health**			**94%**			**85%**			
							Community health			**98%**			**98%**			
Quality Priority 2: Continue to improve the timeliness and ease of people accessing services when they need them	Improving access for people experiencing non-acute mental health problems (routine); face to face contact within 14 days of referral (CKW)	90%	Quarterly	**83.7%**			**81.52%**			78.7%			79.7%			
	Improving access for people experiencing non-acute mental health problems (routine); face to face contact within 14 days of referral (B)	90%	Quarterly	57.94%			63.57%			**83.9%**			**91.5%**			
	Improving access to assessment & treatment for children and young people requiring assessment and diagnosis for autism / ADHD (Wakefield Services children 14years upwards)	No. of assessments per month achieved	Quarterly													
	Reduce the number of people on the waiting list for ASD pathway in Calderdale & Kirklees	Reduction in waiting list	Quarterly													
	CAMHs Barnsley: Patients (routine referrals) seen within 5 weeks of initial referral	100%	Quarterly	14%			4%			Oct 10% / Nov 26%			11.76			
	Snapshot position of percentage of waits to first available appointment at month end, regardless of setting in Barnsley community services (waits greater than 3 weeks)	<10%	Quarterly							**7.8%**			**9.75%**			

Quality priority 3: Continue to improve care, care planning & evaluation of care.	% people offered a copy of their care plan.	85%	Monthly		82	82	82	82	82	82	82	83	83	83	83	83	
	Mental Health currency development: Adherence to cluster reviews –	90%	Monthly		73	73	73	73	72	72	71	71	71	70	69	69	
	Mental Health currency development: % of eligible cases assigned a cluster	100%	Monthly		95	96	96	96	96	96	96	96	96	96	96	95	
	Increase the number of clinical audits that have actions implemented/ demonstrate outcomes	From Q3 5% increase Q4 further 5% increase	Quarterly						Benchmark 28%			40%			35%		
	Implementation of NICE clinical quality standard in one clinical team as a pilot.	Q1 Scope, Q2 Plan Q3 – audit Q4 implement recommendations	Quarterly														
	Identify an outcome measure (s) to be used for service areas.	Q1 Scope, Q2 PlanQ3 & Q4 Identify measures	Quarterly														
Quality priority 4: Improve clinical record keeping and data quality	Implementation of recommendations from clinical record keeping quality forum	Q1 Scope, Q2 PlanQ3 – audit Q4 full implementation of recommendations	Quarterly														
	Mental health currency development: % mental health patients with a valid diagnosis code at discharge	99%	Monthly		91	99	82	100	100	100	100	100	100	100	100	100	
	% of people with ethnicity codes completed	99%	Monthly					94	85	95	96	95	95	95	95	95	
	Implementation of actions in BDU data quality action plans	Evidence of activity against data quality action plan	Quarterly	Barnsley (CS)													
				Barnsley (MH)													
				Calderdale													
				Forensics													
				Kirklees													
				Wakefield													
Quality Priority 5: Continue to improve transfers of care by working in partnership across the care pathway	Delayed transfers of Care (DTOC)	<=7.5	Monthly		3.3	4	4	3.8	3.6	4.9	4.2	4.6	4.9	4.5	3.1	2.2	
	Participation in and implementation of recommendations from of intermediate care pathways	Audit to remain on track	Quarterly														
	Review transition protocols for CAMH's/ Adults interface	Q1 Scope, Q2 Plan Q3 implement Q4 Evaluate	Quarterly														

Quality Priority 6: Ensure that our staff are professionally physically and mentally fit to undertake their duties	**Sickness rate**	**4%**	**Monthly**	4.7	4.8	4.8	4.7	4.6	4.5	4.5	4.6	4.7	4.7	4.8	4.7								
	Development of a trust wide clinical supervision policy for nurses and implementation of audit tool	Q1 scope, Q2 Plan Q3: Tool development Q4: Audit	Quarterly																				
	Staff Friends & Family Test: percentage of scores recommending: Trust as a place to work	80%	Quarterly (Q1,2,4)	62%			56%						56%										
	Our services to friends and family	80%	Quarterly (Q1,2,4)	70%			65%						69%										
	Monitor of mandatory training figures for: Equality & Diversity training	80%	Quarterly	63%			70.2%			77.6%			81.43%										
Quality priority 7: To improve the safety of our service users, carers, staff and visitors	Implementation of MH safety thermometer	Establish system	Quarterly																				
	Pressure Ulcer reporting	< 26	Quarterly	0			2			2			3			7								
	Infection rates of MRSA Infection rates of C Diff	0 <=8	Monthly	0	0	0	1	1	0	0	0	0	0	0	0	2 CDiff							
	Effective monitoring and response to medication errors – adherence to policy timescales 5% increase in people responding within timescales by Q4)	Q1 Scope, Q2 benchmark.	Quarterly				59%			67%			66%										
	Reduction in the number of medication errors entered in the 'other' category. (5% reduction by Q4)						28%			29%			24%										

Key: Green: achieving target Amber: within 10% of target Red =more than 10% away from target Blue: no information expected in the reporting period.

Priority 1: Service users are central to what we do (Listen and act)

Why did we focus on this?

A key element of our approach to quality is ensuring people who use our services always have a good experience. We believe it is important to listen to the feedback we receive and act on this appropriately. South West Yorkshire Partnership NHS Foundation Trust routinely collects patient experience as a key component of our mission to embed quality. Patient experience is a key priority in all our services and is often underpinned by either a CQUIN, part of a commissioning schedule or a contractual agreement.

What progress have we made?

During 2014-15 we have continued to obtain feedback from people who use our services. We have monitored key performance indicators and thematically analysed narrative feedback. We have refreshed the purpose and function of our Patient Experience Group and going forward this will be named Customer Experience Group. Terms of reference have been agreed and membership, for the first time, will include representation from people who use our service and carers. A key focus of this group will be to triangulate all sources of feedback, i.e. complaints, compliments, staff feedback, patient feedback, Trust visit programme, 15 steps programme etc. which will be utilised to inform key priorities for the organisation.

In 2014 we developed a Patient Experience electronic dashboard that enables trust staff to view their feedback in near real time. The narrative comments are included on the dashboard for staff to take action against the areas identified for development and celebrate their success.

Our approach to the development of systems for capturing and acting on patient experience feedback was cited as a good practice example in 'Senior Leadership' category in the National Quality Board's publication ***Improving experiences of care: Our shared understanding and ambition*** (Jan 2015) .

Key Performance Measures 2014-15

We monitored five Key Performance Measures 2014-15s against this quality priority. The table on page 31-33 demonstrates the progress we have made in this area, i.e. that we have achieved all our patient experience goals, with the exception of the inpatient survey goal, which equates to 80% achievement in these measures.

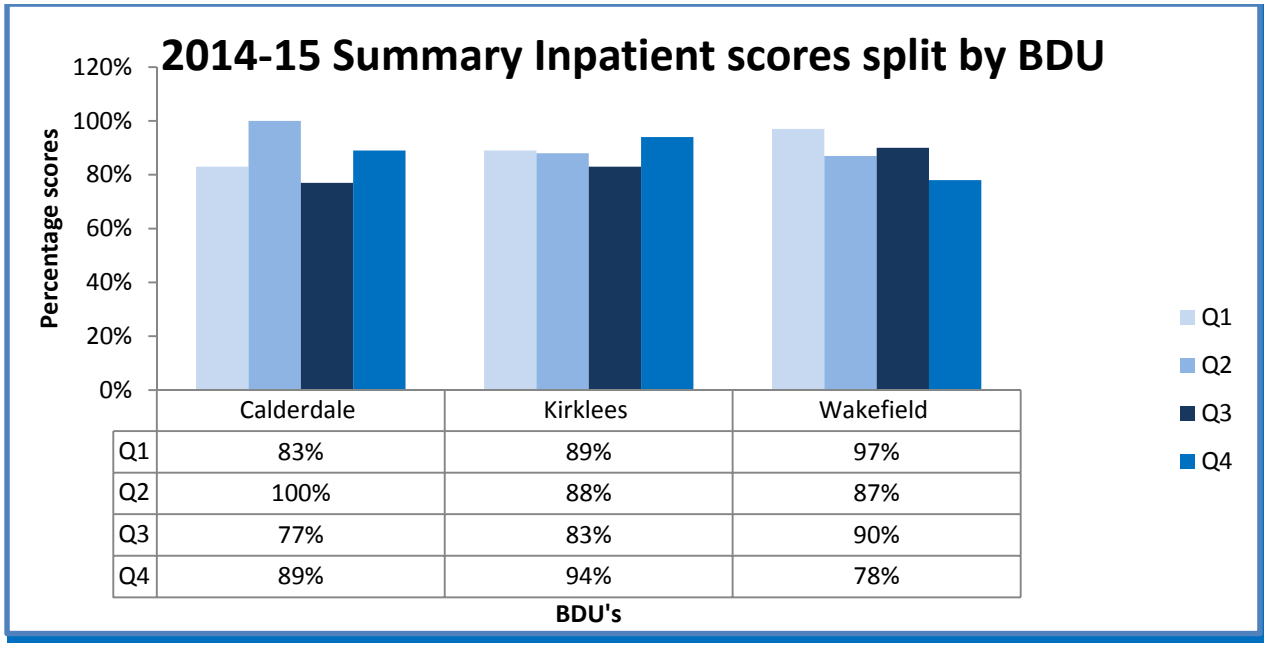
1. **Percentage of people in inpatient mental health (Calderdale, Kirklees & Wakefield) rating care as excellent or good.**

This measure is part of our CQUIN scheme for our commissioners in Calderdale, Kirklees and Wakefield. In previous years we have consistently achieved this goal, however a decision to stretch the goal was taken and we increased it from 75% to 90%. In addition we decreased the number of categories we reported against, i.e. in 2012-13 we reported against feedback that rated our care as excellent, good or fair: from 2013-14 we have reported against feedback that rates our care as good or excellent. We took this action as we believe a 'fair' rating does not meet the standards we want to

achieve. In 2012-13 we achieved 96.4% against feedback that rated our care as excellent, good or fair, in 2013-14 we achieved 82% against feedback rated our care as excellent or good and in 2014-15 we achieved 85% against the later criteria.

Whilst we have narrowly missed achievement of this goal by 5%, we are pleased with the progress that has been made as this is an increase on 2013-14.

The chart below shows the scores achieved by each individual BDU in 2014-15. Detailed information underpins these scores and we are clear that there are a minority of teams who are affecting the overall scores



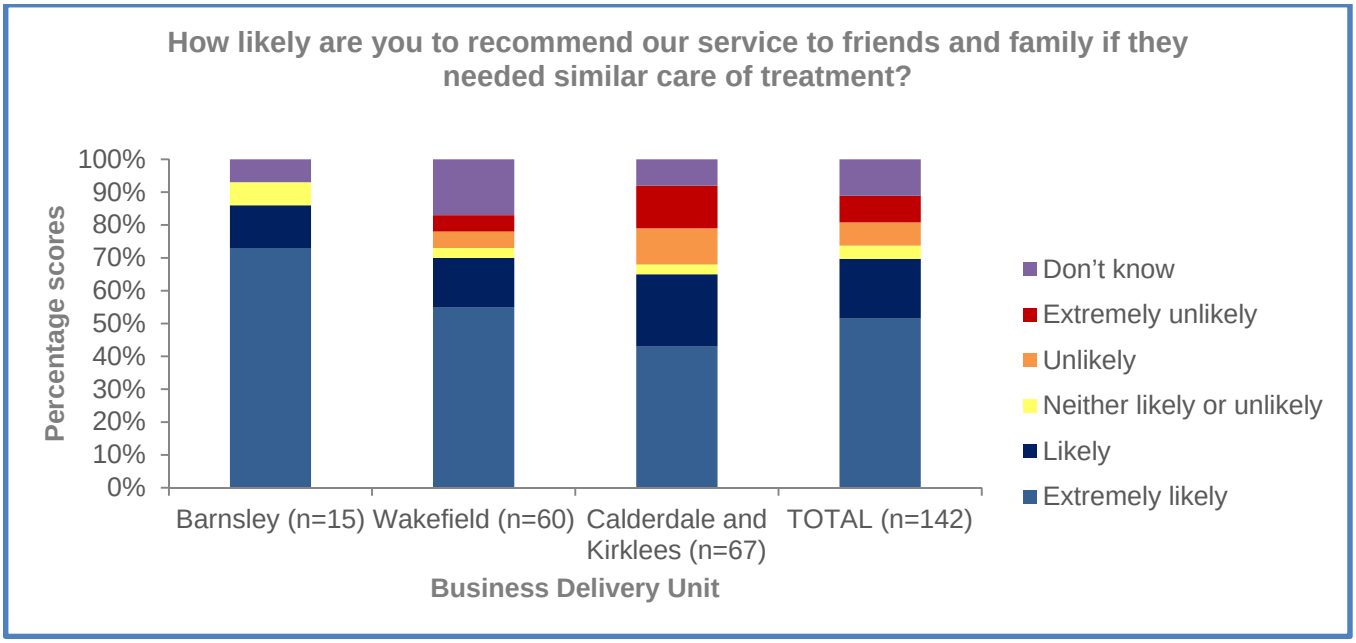
	Calderdale	Kirklees	Wakefield
Q1	83%	89%	97%
Q2	100%	88%	87%
Q3	77%	83%	90%
Q4	89%	94%	78%

.

We take patient experience feedback seriously. We have an active plan in place, involving staff teams, clinical leaders and quality academy colleagues, to work with teams who are struggling to act on the feedback they are receiving

2. **Percentage of people in Child and Adolescent Mental Health service (CAMHS) who are extremely likely/likely to recommend the service to their Friends & Family**

The Friends & Family test (FFT) was introduced to CAMHS for the first time in October 2014, as part of the national FFT implementation by NHS England. Month by month we have seen a steady increase in the number of responses received. In CAMHS we are focusing our efforts on implementing the system to act on feedback we have received, whilst continuing in our quest to increase the number of responses. We have undertaken a focused piece of work to design a child's, and young person's version of our FFT postcard and increased the number of electronic devices that are available for this group as feedback informed us that they are more likely to respond using technology as opposed to a paper survey.



The comments we have received from CAMHS services has been polarizing, i.e. either extremely positive or negative. Whilst most people are happy with the care and treatment they receive once they get into the service, there is discontent at the waiting time to access some services. Some examples of feedback are included below:

What was good about your experiences?

- *"The hospitality and the welcoming faces of the staff"* – Calderdale and Kirklees
- *"Trustworthy support worker and friendly. Good to talk to. Good listener, optimistic and understanding"* – Barnsley
- *"The staff are very nice and kind and stuff"* – Wakefield

What would have made your experiences better?

- *"Therapists are good when you see them but appointments are so sporadic it's impossible for treatment to be effective"* – Calderdale and Kirklees
- *"More focus was on diagnosis rather than treatment. More support / treatment was needed"* – Barnsley
- *"If I could come sooner"* – Wakefield

The CAMHS Governance group will give support and monitor quality improvement action against the feedback received.

3. Percentage of people in Long Term Conditions who are extremely likely/likely to recommend the service to their Friends & Family

Our Long Term Condition teams, part of the community nursing category consistently achieved 97% in their patient feedback across 2014-15. Staff continue to act on the feedback received although this is a challenge as the comments are very positive.

4. Our Commitment to Carers: Benchmarking of elements of Triangle of care across all inpatient services

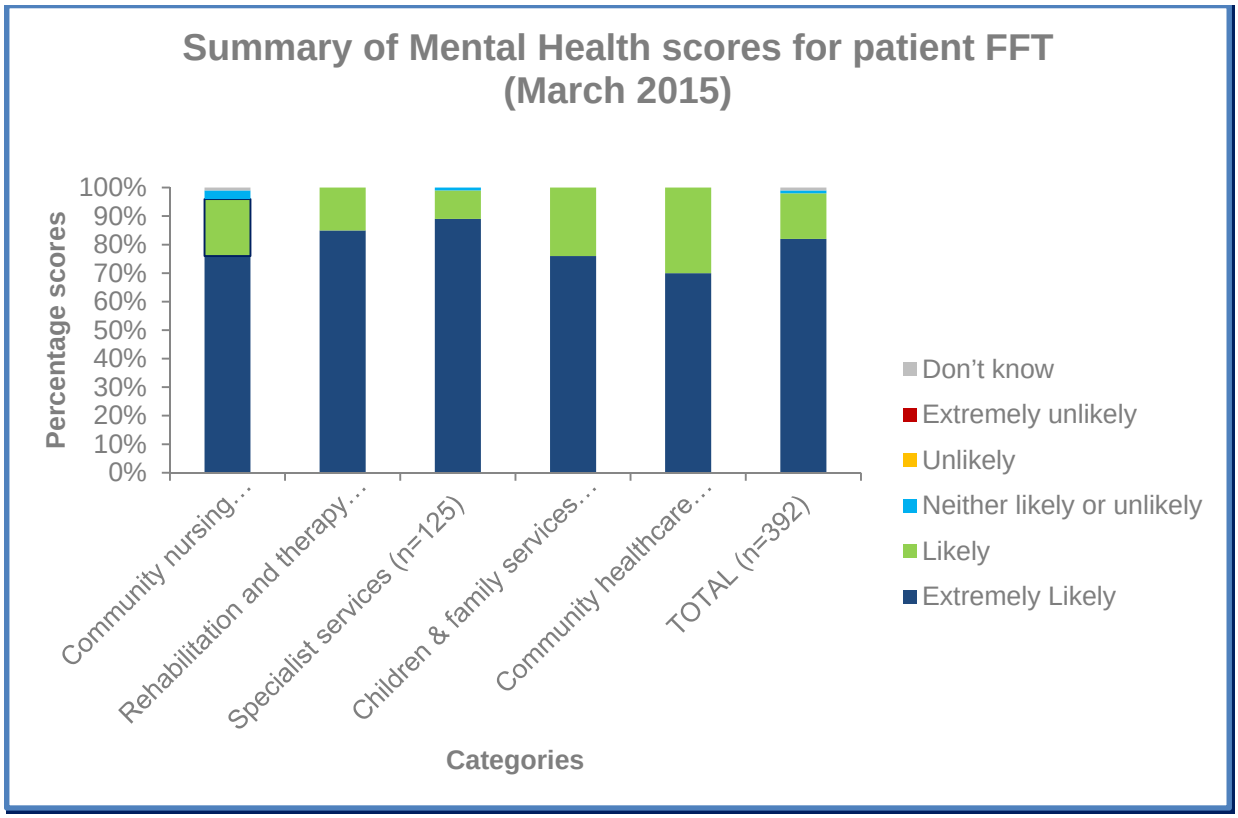
The Triangle of Care was launched as a toolkit, to be used on a voluntary basis, from the National Acute Care Programme. The primary aim was to recognise carers as partners in care. In 2014-15 we committed to benchmark ourselves against 'The Triangle of Care' toolkit on our mental health inpatient wards. The table below summarises the benchmark position:

Standard descriptor	R/A /G Rating	Examples of consistent practice across inpatient areas
Standard 1: Carers and their essential role are identified at first contact or as soon as possible afterwards		Carer involvement in assessment process on admission and throughout the stay to give their views. Carer's contact details recorded. Carers shown around the ward areas. Introduced to staff and made aware of Primary / named nurse. Given opportunity to ask nurse & nursing team re care planning & discharge planning processes explained to them. If carer not present on admission then aim to contact them within 48hrs & invite them to meet nurse on ward to gauge their views. Carers given 'Ward Contact Card' containing address of unit, ward contact numbers & visiting times. Carers invited to attend Multidisciplinary Team meetings & Discharge meetings. Nursing staff document interactions/meeting with carers on RIO under heading of "Carer Contact". Separate 'family' room available for visits of family members under age of 18 years.Carers offered private area/room to have their visit with service user. Trust Information booklet for carers, friends and relative given to carers, which also details ward, contact number, consultant and primary nurse.
Standard 2: Staff are carer aware and trained in carer engagement strategies		An e-learning carer awareness training package available in the Trust. Some wards report that staff are required to complete this training, whilst others report this work needs to be progressed.
Standard 3: Policy & practice protocols re confidentiality and sharing information are in place		Consent to Share information is sought from service user at point of admission – same documented on RIO. If consent is not given at time of admission then this is revisited by Primary Nursing team at regular intervals. If consent is not given then general support is still offered to carer & they are encouraged to share information with the team, their thoughts, and perceptions.MDT reviews the need for disclosure when necessary.
Standard 4: Designated posts responsible for carers are in place		Carer Leads are identified on all wards – the range and grade of staff vary.. Staff are aware of importance of carer inclusion/support. Carer inclusion & support addressed in management supervision.
Standard 5: a carer induction to the service and staff is available, with relevant range of information across the care pathway		Carer's shown around the ward areas. Introduced to staff and made aware of Primary / named nurse. Given opportunity to ask nurse & nursing team re care planning & discharge planning processes explained to them. If carer not present on admission then aim to contact them within 48hrs & invite them to meet nurse on ward to gauge their views Carers given 'Ward Contact Card' containing address of unit, ward contact numbers & visiting times. Carers invited to attend Multidisciplinary Team meetings & Discharge meetings. Improvement needed on carer information across the care pathways.
Standard 6: A range of carer support is available.		Nursing team refer Carer for 'Carers Assessment' when required. Carers Information notice board / leaflets on ward – high visibility, containing information on local carers' services. Family & Carers Care plan as part of Inpatient Recovery Forms on RIO. Carer's groups run by inpatient staff.
Red– no evidence across most teams / Amber: evidence against most of teams /Green sufficient evidence across all team		

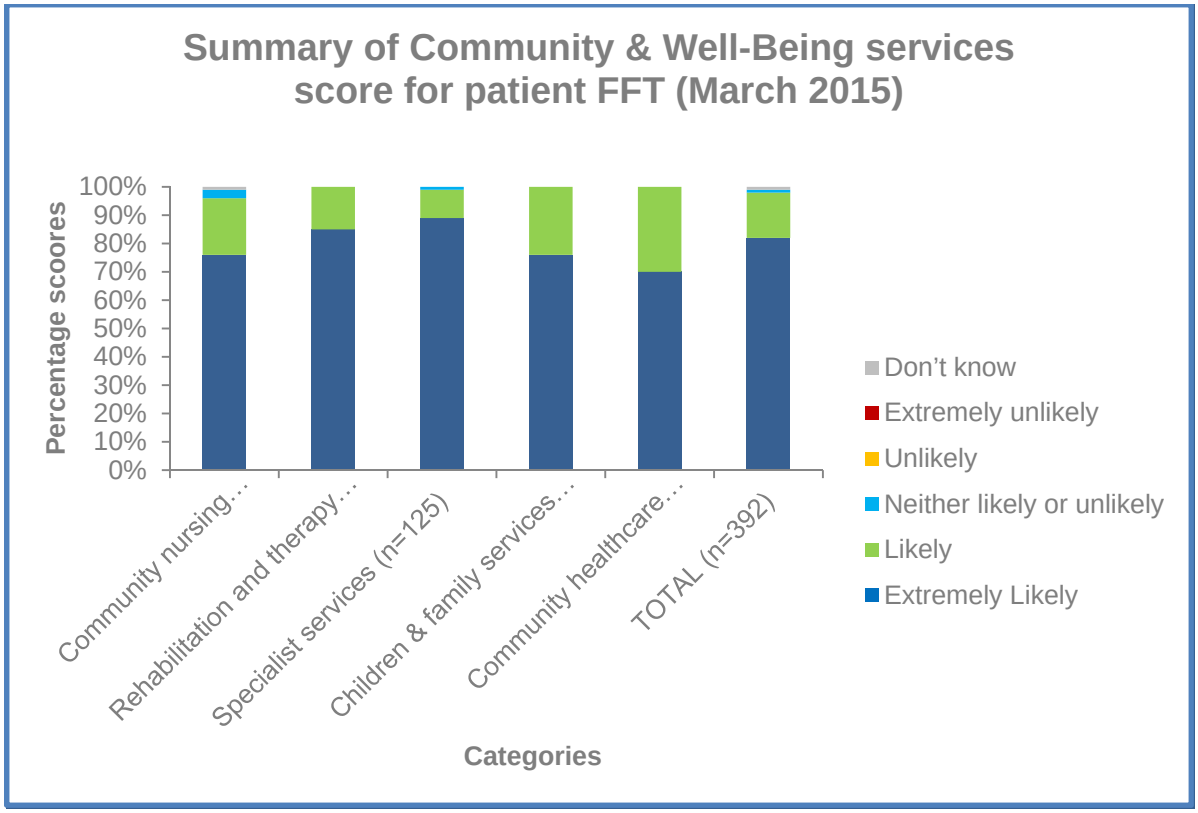
This exercise demonstrates that there is a significant amount of work being undertaken across the wards to improve the experience of carers. Where areas were not meeting the benchmarking standards they could demonstrate they have an active plan in place to address any shortfalls. This work will progress in 2015-16 via the quality improvement group with the aim of establishing consistent practice across all inpatient wards.

5. Patient Friends & Family Test: percentage of scores recommending our services as either likely or extremely likely

The patient Friends and Family Test (FFT) has been successfully implemented across all our services. In March 2015 our Internal Auditors (KPMG) gave us an assurance rating of 'significant assurance with minor improvement opportunities'. We have consistently received positive results which are being shared internally with staff and people who use services. Our Mental Health & Community & Well-Being services results for March 2015 are shown overleaf:



In Mental Health services 80% of people would recommend us to their Friends & Family and 20% were undecided as their response was either 'don't know or neither likely or unlikely'. As expected many people in our Secure & Forensic services are less likely to recommend the services to friends and family. The narrative feedback indicates that whilst people are happy with their care and treatment, understandably they would not recommend the loss of liberty.



In Community & Well Being services 98% of people would recommend our service to their Friends & Family, 2% were undecided.

What next?

Throughout 2015-16 we will continue with our commitment to listen to people who use our services and continue our exploration of methods of obtaining feedback. We will focus on acting on the feedback we receive and embedding the patient experience cycle throughout our clinical services.

Priority 2: Timely access to services (Access)

Why did we focus on this?

We want to improve access times for people who are referred into our services so they get the right support from the right service at the right time.

What progress have we made?

We monitored ourselves against 6 key performance indicators in relation to access to services and we achieved 4 of these goals, which equates to 67%. The table on page 31-33 demonstrates the progress we have made in this area.

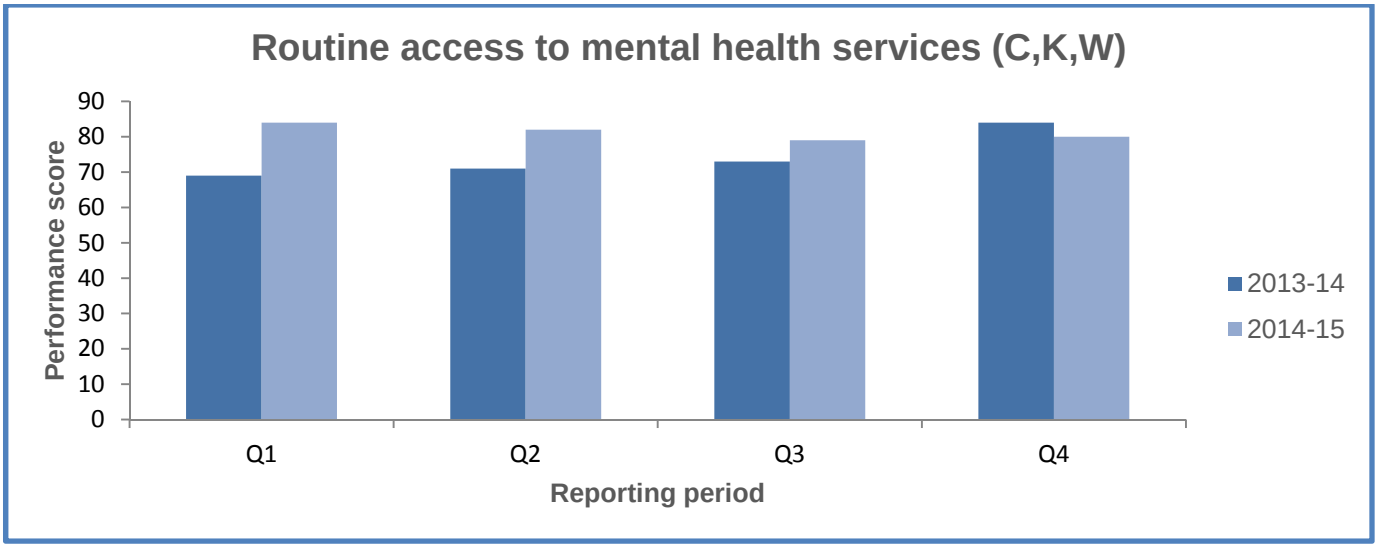
Key performance measures 2014-15.

1. Improving access for people experiencing non-acute mental health problems

The charts below shows our performance against our routine access goals in mental health services - our aim is to respond within 14 days, and is monitored by our commissioners as part of our contract agreement. In our collective calculations for Calderdale, Kirklees and Wakefield services the performance has fluctuated throughout the year and at the end of the year performance was below the goal. In our Barnsley services, the goal was achieved.

1.1. Calderdale, Kirklees and Wakefield

The chart below shows how we have performed against this measure over the last two years.



During 2013-14 our performance against this measure gradually increased throughout the year, and in 2014-15 the performance was overall better than in 2013-14, with the exception of Q4, where we saw a minor decline in performance. However the number of people seen within 14 days did actually increase as the number of referrals we received in 2014-15 increased from 2013-14. A breakdown of the performance figures by service line identifies that generally the Older People's service line are achieving this goal across all three BDU's, however in Adults' service line the picture is different. The table below breaks down this measure into the respective BDUs adult service lines, to allow us to understand performance at this level.

BDU	Variance in performance scores across 2014-15	End of year position (March 2015)
Calderdale	46.9% -72%	50.70%
Kirklees	52.63% - 84%	52.63%
Wakefield	69.4% - 88.64%	88.64%

As the tables shows Wakefield BDU are achieving the goal at March 2015 (year-end), whilst Calderdale and Kirklees are not.

The performance across Calderdale and Kirklees has fluctuated over the year. In response to this the BDU has taken the following action:

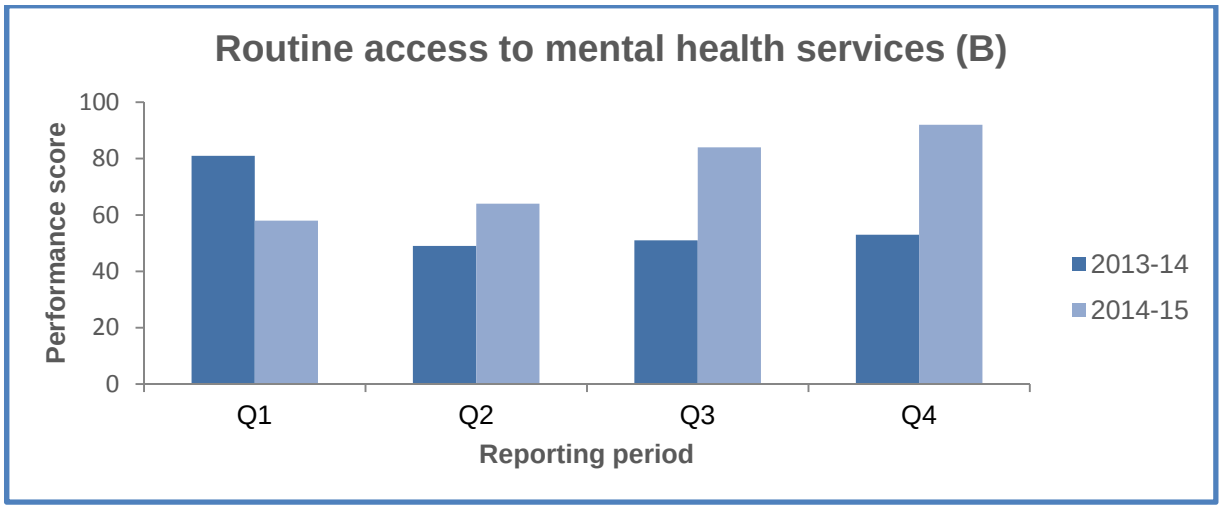
- In Kirklees there has been close working between the Single Point of Access (SPA) team and Community Mental Health Teams (CMHT) and focussed work to increase the number of assessment appointment slots for medical staff
- In Calderdale an increase in number of assessment clinics available.

The impact of these initiatives is being monitored by the management team.

Across the trust as part of the transformation programme in 2015-16 SPA will be integrated into the core community pathway and all initial assessments will be carried out by them. We know this model is successful as this model of working has been effective in our Barnsley mental health services.

1.2 Barnsley

As the chart below shows performance against this measure has been improved through the introduction of a pilot SPA from 1st December 2014, operating a seven days a week assessment service -Mon- Fri 08.00-21.00 Sat 08.00- 16.00 and Sun 08.00 – 13.00.



All referred clients are telephoned and offered a choice of where and when they are seen as soon as the referral is received and sent an appointment. This aids efficiency with minimal effort we have found that giving people the choice of appointment times reduces the rates of people not attending appointments and the initial call engages the person with the service.

2. Access to CAMHS services

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Most children and young people with mental health problems will be seen at Tiers 1 and 2. However, it is important to bear in mind that neither services nor people fall neatly into tiers. For example, many practitioners work in both Tier 2 and Tier 3 services.

Similarly, there is often a misconception that a child or young person will move up through the tiers as their condition is recognised as more complex. In reality, some children require services from a number (or even all) of the tiers at the same time.

The model provides a framework for ensuring that a comprehensive range of services is commissioned and available to meet all the mental health needs of children and young people in an area, with clear referral routes between tiers.

The Trust is the provider of Tier 3 services in Calderdale, Kirklees, Barnsley and Wakefield which means we provide specialist multi-disciplinary outpatient teams providing a specialised service for severe, complex and persistent disorders. Team members include psychiatrists, psychotherapists and occupational therapists. During 2014-15 we measured three access performance measures for our CAMHS services.

- Wakefield CAMHS: Improving access to assessment & treatment for children and young people requiring assessment and diagnosis for autism spectrum disorder. We achieved this goal.
- Calderdale and Kirklees CAMHS: we said we would reduce the number of people on the pre April 2014 waiting list. With additional resources we achieved this goal in that we have reduced the waiting list. We acknowledge that there remains significant work to do to in reducing waiting lists and improving access to some areas of this CAMHS service.
- Barnsley CAMHS: we monitored the percentage of routine referrals seen within five weeks of initial referral. We did not achieve this goal and in 2015-16 we will give this measure priority and aim to achieve the waiting times currently being agreed with our commissioners.

3. **Access to Barnsley Community Services:** Snapshot position of percentage of waits to first available appointment at month end, regardless of setting.

This indicator for 14-15 is reported as a snap shot position of first available appointment, regardless of setting for each service. The target goal for this measure is less than ten per cent of services should not have a wait of longer than three weeks. We achieved this goal.

In 2015-16, as part of the monitoring schedule, we will develop this measure further and measure the percentage of people that are seen within 3 weeks.

What next?

In 2015-16 we will continue to drive improvements to access for people in children's, adult and older people's mental health services plus access improvements made as part of the Tele-health developments. Our transformation programme will be key to ensuring that this happens.

Priority 3: Improve care and care planning (Care planning)

Why did we focus on this?

We believe that individualised personal care is essential to enable a person's recovery. Everybody should have an appropriate assessment of their needs and an individualised care plan that supports them in achieving their goals.

What progress have we made?

In 2014-15 we monitored six Key Performance Measures 2014-15s against care and care planning quality priority, which is discussed below. The table on page 31-33 demonstrates the progress we have made in this area:

Key performance measures 2014-15

1. **Percentage of people offered a copy of their care plan.**

The trust has set itself a local goal of 80% of people offered a copy of their care plan. For the purposes of the quality account monitoring this figure was revised in 2012-13 to add a stretch to the goal. At the end of 2012-13 our performance figure was 84%, in 2013-14 we saw a steady decrease in the number of people being offered a copy of their care plan and we achieved 81% at year end. Throughout 2014-15 this key performance measure has fluctuated between 82% and 83% meaning that the quality account goal of 85% is not being achieved despite the actions we implemented.

There has been a decision at a national level to remove this question from the CQC community survey as it is recognised that a 'care plan' can come in many different guises depending on the function of the team or professional a person is engaged with.

In 2015-16, as part of our CQUIN scheme in Calderdale, Kirklees and Wakefield we will replace this measure with one that aims to improve the quality of care plans thereby improving care and communication between teams and clinicians and ultimately increasing safe care delivery. This measure also aims to improve an individual's involvement in the development and review of care plans.

The care plan will include the following elements:

- Evidence of co-production
- Evidence of person-centeredness through specific and personalised planning
- Evidence that if a carer has been identified, their needs and views have been taken into account
- Evidence of identified risks and how they will be managed and addressed
- Evidence of a comprehensive staying well plan, in the form of crisis and contingency planning containing:
- Early signs of relapse
- Individualised response plans to signs of relapse
- Up to date and accurate contacts and information

We will report on this measure on a quarterly basis through the quality account reporting structure.

2. **Mental Health currency development percentage of eligible cases assigned a cluster & adherence to cluster reviews.**

The indicator percentage of eligible cases assigned a cluster and percentage adherence to cluster review periods have been monitored throughout 2014-15 and are part of the national data set for the proposed future commissioning arrangements for mental health services.

Undertaking the assessment to assign someone a cluster and care package means that they will be in receipt of the correct care and treatment to meet their needs. The timely review ensures that a person continues to receive the right care and treatment; hence these measures are particularly important in ensuring a person receives the right care and treatment to achieve their goals.

Our performance scores for the past 3 years 'for assignment to cluster' are as follows:

- 2012-13 = 96.5%;
- 2013-14 = 95%
- 2014-15 = 96%

Over the years we have maintained a near static position of 96%.

Our performance scores for the past 2 years for 'adherence to cluster review' are as follows:

- 2013-14 = 73%
- 2014-15 = 69%

Over the past 2 years the month on month position has fluctuated and we acknowledge a variance in practice within each BDU and professional groups, which has contributed to us not achieving the goal we set for ourselves.

The following action is planned to address the lack of progress:

- Caseload reviewers will be appointed to data cleanse caseloads
- The care pathways work stream will be centralised within the new clinical and management structure
- Changes will be made to the electronic record keeping system aligned to the care pathway structure
- Our Care Pathways & Packages dashboard is being reviewed
- Further developments to the ongoing training programme
- A four part CQUIN has been agreed with our commissioners to ensure accurate clustering and timely reviews.

3. **Increase the number of clinical audits that have actions implemented.**

The purpose of clinical audit is to improve the quality of care being provided. It is at the heart of providing the necessary changes in practice to ensure that SWYPFT is delivering efficient, person focused, high quality care and treatment.

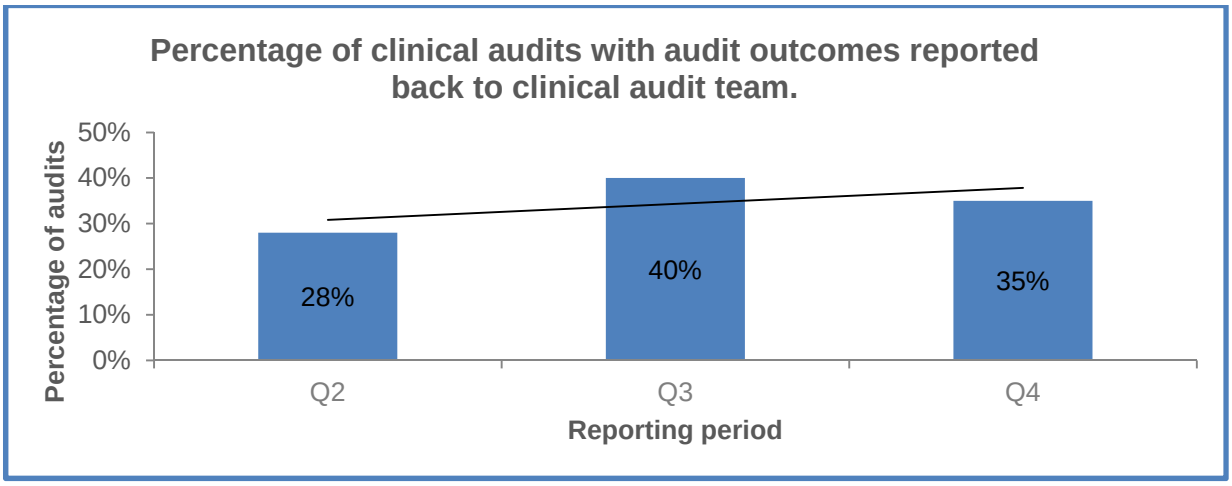
We included this local measure in response to recommendations made by our internal auditors in 2013-14. Whilst we received a rating of 'significant assurance' they made a recommendations that to strengthen organisational assurance processes there was a need for all clinical audit projects to

be followed up by the clinical audit team, to make sure that the appropriate actions are delivered (audit outcomes).

The clinical audit team reviewed the processes that were in place to follow up on actions delivered as a result of clinical audit reviews. Each person that has undertaken a clinical audit is now contacted six months post audit and asked for an update against the expected actions (audit outcomes).

To measure the efficacy of the actions taken, we have monitored this measure throughout 2014-15. New systems were implemented in April 2014, and a trajectory increase of five percent per quarter of the number of audits with outcomes reported back to the Clinical Audit team was set.

The chart below shows how we performed each quarter.



Between quarter two (Q2) and quarter three (Q3) we had an increase of twelve percent of audit outcomes reported to the clinical audit team however between quarter three (Q3) and quarter four (Q4) this figure decreased by five percent, giving an overall increase of audit outcomes reported of seven percent.

A review of this data highlighted the following:

- The clinical audit team are consistently following up action plan outcomes
- The feedback from the review is:
    - In the majority of cases the recommendations from the audit have been verbally reported as being implemented – however no formal action plan has been documented.
    - In a minority of cases there has been no action taken. The reason for this is that actions are being taken forward as part of a service redesign, so are effectively on hold until the redesign occurs.
- During Q1 'link' roles were established in BDU's with a lead clinician responsible for clinical audit. Following a review of the leadership and management arrangements between September and November 2014 there is now a need to refresh the BDU 'link' roles.
- In areas where clinical audit is discussed as a standing agenda item on the BDU Governance meetings improvements have been noted in the response to audit outcome requests.

Whilst this review does give some assurance that the majority of findings from clinical audit are acted upon there remains a lack of evidence to support this. During 2015-16 we will continue to strive to improve our performance in this area. Actions that we will take are:

- Reinforce the expectations of the processes of clinical audit with clinical teams.
- Strengthen the partnership role between BDU's and the clinical audit team.
- Review how and when we collect audit outcome data.

It is important to note that irrespective of this concern with formally 'closing the loop' on clinical audit activity our internal auditors are satisfied that overall our clinical audit systems and processes are robust and a review in February 2015 gave us a 'significant assurance' rating.

4. Review of a NICE clinical quality standard in a clinical team

As part of our local annual audit programme we undertook an audit against the NICE Quality Standard for Health & Wellbeing of Looked After Children (National standard QS31) in our Calderdale & Kirklees CAMHS services.

The NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality:

- clinical effectiveness
- patient safety
- patient experience.

NICE quality standards enable:

- Health and social care professionals to make decisions about care based on the latest evidence and best practice.
- Patients and carers to understand what service they should expect from their health and social care provider.
- Service providers to quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- Commissioners to be confident that the services they are purchasing are high quality and cost effective.

A sample of ten case records were used in our audit and we concluded that due to the lack of fully completed clinical records it was not possible to confirm full compliance with this aspirational standard. The recommendations from the audit are:

- Staff to be made aware of the requirements of the quality standard through bespoke training undertaken by the Compliance Manager and Practice Governance Coach.
- The findings of the audit to be shared at the CAMHS Clinical Governance Group to identify transferable learning.
- Action plan to be developed by CAMHS Clinical Governance Group.
- Re-audit to be undertaken in January 2016.

The audit report is due for consideration at the CAMHS Clinical Governance Group in May 2015 and an action plan will be developed based on the detailed findings. We will update our progress in our 2015-16 quality report.

5. **Identify an outcome measure to be used for mental health services.**

During 2013-14 and 2014-15 SWYPFT participated in a national pilot project to evaluate the utility of the short seven item version of the Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) as a generic patient rated outcome measure across the 21 mental health clusters. The aims of the pilot were to establish collectability/response rates overall and by mental health cluster, how sensitive to change over time SWEMWBS is with different clinical populations, and to ascertain staff and service users views about SWEMWBS suitability for use within secondary care mental health services.

Summary points from the pilot testing are:

- People were more willing to complete the SWEMWBS at discharge. Response rates for completion at assessment and review were low and hence outcome evaluations were unable to be calculated (as two scores are necessary for comparison over time).
- There was insufficient data with which to evaluate SWEMWBS's sensitivity to detect change overtime by cluster.
- The majority of staff were not supportive of SWEMWBS and felt other patient reported outcome tools were more appropriate for secondary mental health services.
- Generally service users were supportive of SWEMWBS for use within mental health services. However, there were concerns about the negative impact completing it had on some service users' mental state and the appropriateness of giving it to people who are unwell. They also raised concerns about the wording of some of the statements being confusing for some service users. Service users from ethnic minority groups also raised significant concerns about some of the statements and felt they could be misconstrued by people from different cultural backgrounds.

In SWYPFT we had anticipated that SWEMWEBS would be implemented across our mental health services, however given these findings we are now reconsidering and a number of small project groups have been convened to test out alternative outcome tools.

What next?

Throughout 2015-16 we will continue with our commitment to improve the quality of care. We will

- focus on the quality of care plans across our mental health service
- engagement of people in our forensic services with the assessment of risk
- continue to monitor the number of people who have had an assessment of their needs and had a cluster assigned
- measure the use of clinically relevant outcome tools across the Learning Disability service, and mental health services and use these to contribute to monitoring the effectiveness of treatments and interventions.

Priority 4: Improve recording keeping and data quality (Recording care)

Why did we focus on this?

We want to record each intervention in a timely manner. This is vital in providing safe, effective clinical care and being able to provide assurance to our regulators and commissioning groups on the quality of service provision.

What progress have we made?

We monitored four key performance measures against this quality priority. The table on pages 31-33 demonstrate the progress we have made in this area, i.e. that we have achieved three out of four goals which equates to (75%).

Key Performance Measures 2014-15

1. **Implementation of recommendations from clinical record keeping quality forum**

Nationally it is essential that organisations undertake audits of clinical records in all specialities to ensure that the quality of the health record facilitates high quality treatment and care and that subsequently the health record can justify any decisions taken if required. Accurate records are essential to support high quality treatment and care. Inaccurate records can lead to delays in patients receiving treatment, inappropriate care and duplicate records, which all present risk to the patient.

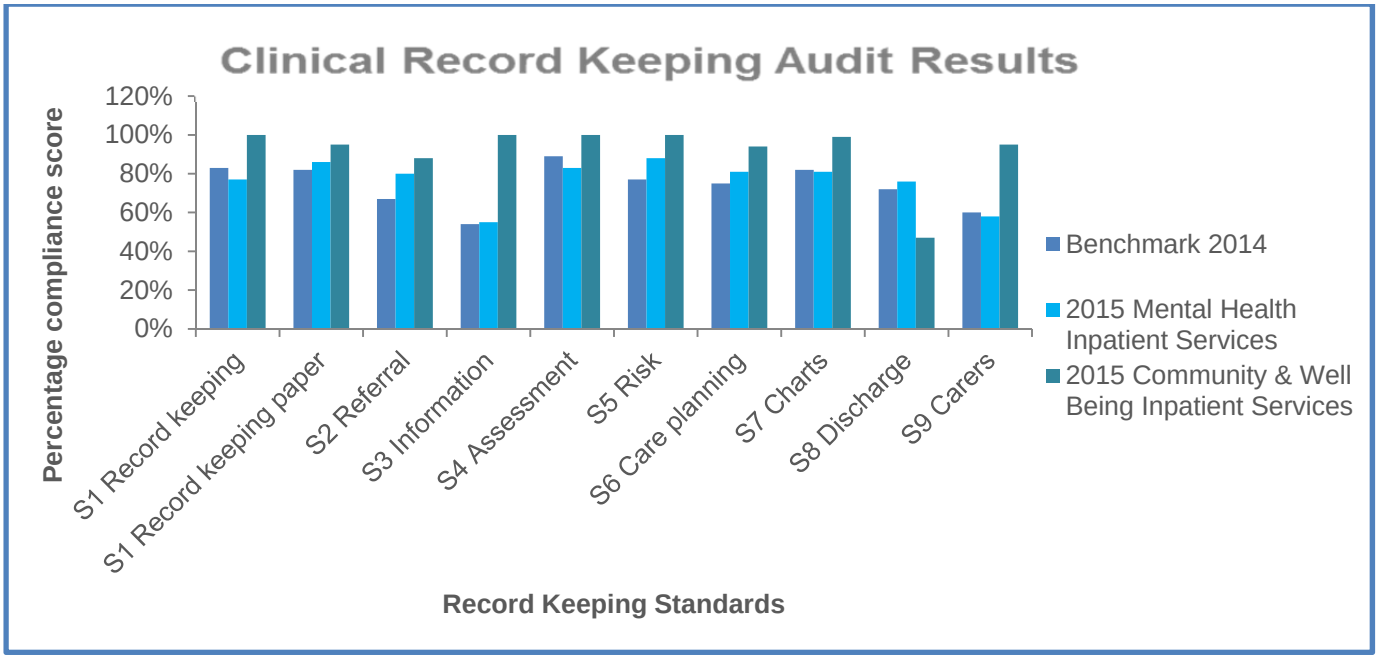
Over the past two years we have focussed on clinical record keeping and data quality as a local key trust objective. In December 2013 we held a Quality Forum on Clinical Record Keeping and identified a number of key actions (reported below) for improvement that have been completed.

The first action was to refine the trust's clinical audit tool and develop an annual audit programme for clinical record keeping. Tools that existed within the trust were revised by a team of clinical staff and the benchmark audit took place in quarter four 2013-14. Throughout 2014 the clinical record keeping standards were further refined following feedback from this initial audit. Each group of clinical teams (e.g. Forensic inpatient wards) now have a bespoke clinical record keeping audit, framed around nine key subject areas, with a common core set of questions. Results from the 2015 record keeping audit can be found on the chart below alongside the 2014 benchmark audit.

From the chart below it can be seen that there was a decline in four of the Mental Health Inpatient Services scores from 2014. The areas of decline are S1 Record keeping (demographic data) – 5%: S4 Assessment – 6%; S7 Charts – 1%; S9 Carers – 2%. In all other areas the Mental Health Inpatient Services scores increased, with a rise of between 1% and 13%.

For Community & Well Being Inpatient Services there was one area where performance declined, i.e. S8 discharge which declined by 25%, however compliance against all other standards increased between 11% and 46%.

The clinical record keeping audits will continue to be monitored via local BDU Clinical Governance Groups as well as the Data Quality Strategic Group.



The second action from the quality forum was to ***develop an e-learning package*** to help raise awareness of data quality issues and responsibilities to all staff in the Trust. Over the past twelve months a small team of people have revised the e-learning training package (that was available from Yorkshire & the Humber), and with consultation from a range of clinical staff developed a tool that meets the needs of our staff.

It is intended to utilise this tool as an aid when working with areas/teams with poor data quality; all new clinical staff at induction and as part of the Trust's e-learning as voluntary training for any staff member.

2. Mental health currency development

Percentage of people with a valid diagnosis code at discharge and percentage of people with ethnicity codes completed

We monitored these measures in 2014-15 as part of the national data set for the proposed future commissioning arrangements for mental health services. From quarter two we have consistently achieved 'percentage of people with a valid diagnosis at discharge' however we have not achieved the goal we set for percentage of people with ethnicity codes completed. This measure will be used in the future as a Quality Indicator in the mental health payment system and we will continue to take action to improve this measure, which will be monitored through the BDU governance processes.

3. Data Quality Action Plans

In our 2013-14 quality account report we said we would monitor data quality action plans through our Data Quality Strategic Group in 2014-15. This is a local measure set in response to concern re data quality in our services. Early in the year (2014-15) improvements were made to our Business Intelligence dashboards (performance reports). In addition to this our management and leadership

teams changed the way they focussed on improving data quality in that on a monthly basis, when the performance reports are available they have systems in place for scrutinizing their data. This improved process of reviewing data quality, in a timely manner, provides a robust way of assuring data quality and supersedes our previous plans.

What next?

In 2015-16 we will continue to prioritise clinical record keeping and data quality as we believe we have room to improve in this area. The Data Quality Strategic Group is convening a workshop early 2015-16 to engage with clinical staff and further understand the barriers to providing consistently good clinical records. To achieve our aim of being able to provide assurance to our regulators and commissioning groups on the quality of service provision we know we have to prioritise this area.

Priority 5: Improve transfers of care by working in partnership across the care pathway (Care pathways)

Why did we focus on this?

We want to support service users to move along the care pathway in a timely way. We also want services to communicate effectively to prevent duplication or gaps in service provision.

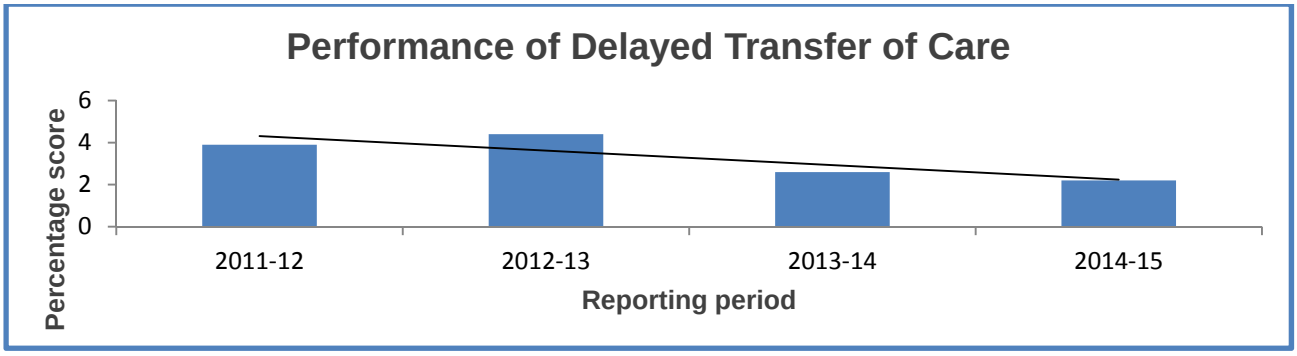
What progress have we made?

Key Performance Measures 2014-15

We monitored three key performance measures against this quality priority. The table on page 31-33 shows the progress we have made in this area, i.e. that we have achieved 100% of our care pathway goals.

1. **Delayed transfers of Care (DTOC)**

A Delayed Transfer of Care is a national measure that we report to our regulator, Monitor. A delay in a transfer occurs when a person is ‘medically’ ready for discharge and is still occupying a hospital bed. We monitor this measure as it gives us an indication of whether our internal systems and those we have with our partner agencies are ensuring we are providing the right care, in the right place at the right time. The chart below shows our performance against the DTOC measure over the past 4 years. The target for this measure is below or equal to 7.5% of all admissions should be recorded as delayed, hence the lower the figure the better.



In May 2014 we introduced a Standard Operating Procedure to provide guidance to staff on Delayed Transfers of Care as we believed there was an inconsistency in the clinical decision making processes underpinning this measure. In February 2015 we asked our internal auditors to audit the robustness of our processes, using data from April 2014 to January 2015.

The audit concluded that testing of the delayed transfer of care indicator identified an inconsistency in the reporting of the denominator used in the calculation; in Barnsley BDU, patients on leave from their regular ward are included as occupying a bed in that ward, while in the other BDUs they are excluded.

In addition, in some cases patients were identified as being able to be discharged and so recorded as delayed when there was no evidence of a multi-disciplinary team meeting or decision of the delay transfer of care recorded on the Trust's Clinical information system (RiO), which is required by the indicator.

Recommendations from the audit include; that the Trust should seek to make sure we record delayed transfers of care accurately so as not to exaggerate the number of delayed transfers of care; the Trust should seek guidance from NHS England and then make a clear policy decision as to whether to include or exclude patients on leave from the calculation of the indicator; and staff completing the data returns on the ward should be reminded of the requirements for assessing a patient as a delayed transfer case, i.e. the requirement for a multi-disciplinary team to review the patient prior to being classified as a delayed transfer, and of the importance of recording the correct discharge dates.

In response to this audit we are reviewing our DTOC Standard Operating Procedure as part of the move to electronic reporting from RiO and will be updating the recording guidance to reflect this. This will also provide an opportunity to re-enforce adherence to the policy and the recording of the required MDT meetings on RiO and will resolve inconsistencies in discharge dates as the discharge date would be extracted directly from the clinical system.

An audit of the implementation of the DTOC standard operating procedure is scheduled for October 2015.

2. National Audit of Intermediate Care

In 2014 Barnsley Community Services participated in the National Audit of Intermediate Care. Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system –

community services, hospitals, GPs and social care. The audit covers organisational level data relating to the period 2013-14.

2.1 Quality Standards - Compliance Rate

Barnsley scored more than 80% on 21 out of 30 questions which is something we are proud about.

We have extracted some of the areas where Barnsley scored lower than the national average and comments within the table outline the reasons why this may have occurred as well as identifying any actions for improvement.

BED BASED Quality Standards National Compliance Goal 80%		
Standard	**Barnsley position**	**Action Point/Comment**
Have all members of the team received training in mental health and dementia care?	69.38%	New Intermediate Care specification is due to be implemented from April 2015. In process of drafting training plan/skills mix review which will include this
Is there a shared electronic patient record?	45.56%	Awaiting full implementation of SystmOne. Currently only activity is input to the system. Bed based data is input on RiO. There currently are 4 wards using 3 different systems

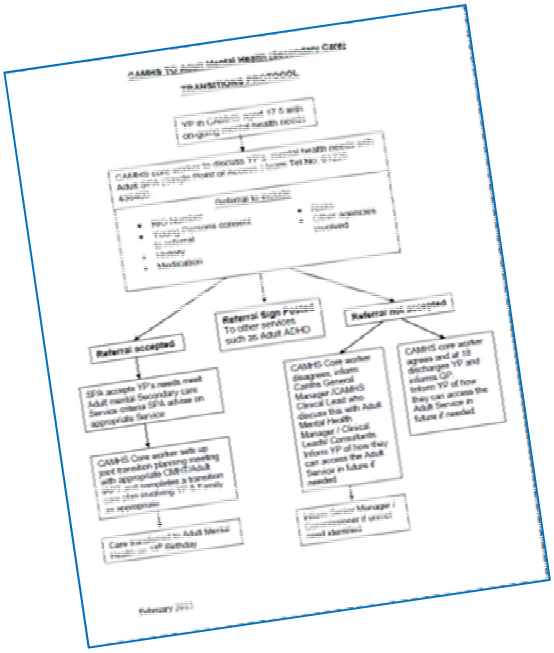
HOME BASED Quality Standards National Compliance Goal 80%		
Standard	**Compliance Rate**	**Action Point/Comment**
Have all members of the team received training in mental health and dementia care?	64.39%	New Intermediate Care specification is due to be implemented from April 2015. In process of drafting training plan/skills mix review which will include this
Is there a shared electronic patient record?	54.14%	Currently awaiting full implementation/rollout of SystmOne
If not electronic is there a comprehensive shared paper patient record?	62.12%	Currently developing a new single assessment tool along with a specialist therapy assessment tool.

CRISIS RESPONSE Quality Standards National Compliance Goal 80%		
Standard	**Compliance Rate**	**Action Point/Comment**
Is an MDT meeting held at least once per week within the service?	79.55%	Daily handover meeting takes place including all disciplines except doctors (i.e. nurses, social worker, OT and Physio)
Have all members of the team received training in mental health and dementia care?	75%	New Intermediate Care specification is due to be implemented from April 2015. In process of drafting training plan/skills mix review which will include this
Is there a shared electronic patient record?	53.19%	Currently awaiting full implementation/rollout of SystmOne
If not electronic is there a comprehensive shared paper patient record?	60.47%	Currently developing a new single assessment tool along with a specialist therapy assessment tool.

3. Review transition protocols for CAMH's/ Adults interface

Recommendations from national guidance, plus internal recommendations from a serious incident and service transformation changes underpinned the need to review our CAMHS transition protocols.

Work has progressed as planned in CAMHS services to update our transition protocols in line with service transformation. Barnsley CAMHS are leading the work that will be rolled out across CAMHS teams during 2015-16. To date a revised protocol has been developed and implemented for transition between CAMHS and adult mental health services and work is progressing to review transitions between CAMHS and psychological therapy (IAPT) and Learning Disability services.



An audit of the compliance with the transition protocol for CAMHS and adult services is scheduled for November 2015.

What next?

Throughout 2015-16 we will continue with our commitment to improve transfers of care by working in partnership across the care pathway. We will focus on implementation of our Delays Transfers of Care Operating Procedure; continue to review our CAMHS transition protocols, improve communication with General Practitioners and implement the CPA framework in CAMHS services.

Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake do their duties

Why did we focus on this?

We know that our staff are our most valuable asset. We are committed to valuing our workforce and know that staff who feel valued and engaged are more likely to provide excellent care.

What progress have we made?

We monitored four key performance measures against this quality priority. The table on page 31-33 demonstrates the progress we have made in this area, i.e. that we have achieved two of these priorities and have not achieved two goals.

Key performance measures 2014-15

1. **Sickness rate**

Throughout 2014-15 we have continued to monitor our sickness absence figures which have fluctuated between 4.5% - 4.8% against our Trust goal of 4%. Over the past 4 years our performance against sickness absence has reduced as the table below demonstrates:

Year	Sickness absence figure
2011-12	5.09%
2012-13	5.31%
2013-14	4.9%
2014-15	4.7%

The national target for sickness absence is 5%; hence whilst we have not met our goal, we have surpassed the national target. The programme of work in this area continues to have high priority in the Trust. Workforce Plans include highly detailed action plans in place to address absence levels with a directive to reduce absence rates. The objectives follow the same guidelines and are summarised as follows:

- Overview of typical Workforce Objectives within Workforce Plans regarding absence reduction.
- Significant overall reduction in average days lost per employee.
- Targeted absence management work within Additional Clinical Service roles and Nursing roles.
- BDU adherence to the 15-point plan in order to reduce absence overall.
- Reduction of instances of absence recorded as ‘Unknown’ in Electronic Staff Record (ESR)
- Review of Payroll Processes surrounding the reduction of ‘not known’ absence being record within ESR.
- Targeted absence reduction in Band 3 healthcare support roles.

- Targeted absence reduction in Band 5 staff nursing roles.
- Agreed action plans implemented with Service Leads, supervisors and relevant HR advisors in identified hot spot areas to target absence reduction and achieve SWYFT absence targets.
- Reduction of current long term absence burden upon the BDU (Currently 78% of all absence).
- Reduction of stress related absence within the BDU (Currently 1 in every 5 days lost to stress related absence).
- Increased collaborative action regarding support for staff back to work from long term absence including Operational leads, HR, OH and Staff side.

The Board set a revised overall Trust wide absence rate target of 4%, (which was reduced from 4.25% in 13-14) The Trust absence rate for the last 12 months was of 4.8%, which was a further 0.2% reduction from 2013-14 and the 4th yearly reduction in a row. The Board and Executive Committee sees the continued reduction of absence as a key performance target and one which will have a positive impact financially in the reduction of dependency upon bank, agency and additional hours costs within the Trust.

The Trust is now amongst the lowest ranked MH Trusts in the NHS regarding the overall absence rate and is the joint lowest of all MH Trusts in the north of England (NHS iView dataset – like for like sized MH Trusts). The Trust set out a 2 year projection in 2014 (within the Annual Plan and Workforce) plans to reduce the absence rate to 4% within 2 years through measures identified above. The Trust's current position of 4.7% by December 2014 is slightly higher than planned and this is believed to be due in part to large scale Transformational change within all areas of the Trust. Reducing absence rates within the Trust Inpatient areas has been identified as a particular focus for success in achieving continued absence reduction.

The Trust continues to improve the management and partnership working of absence reduction with further collaborative working between Operational leads, HR Quality Academy support, Occupational Health support and staff side involvement. The Trust also continues to strengthen the management information regarding absence within e-rostering improvements, BDU performance reports, regular position statement reporting direct to Board and Absence Projections Reporting which identifies hotspot areas and teams. The recently revised Sickness Absence Policy has strengthened the Trust's position on supporting long term staff back to work and staff wellbeing. 14-15 has seen an increase in the number of staff on long term absence returning successfully to work. The Trust has also in the past 12 months undertaken focused work around resilience with Robertson & Cooper (Consultants) in specific areas aimed at reducing absence.

2. Development of a trust wide clinical supervision policy for nurses and implementation of audit tool

The importance of Clinical Supervision for all practitioners is well recognised as a means for ongoing development and reflection on practice. We have developed this local measure to ensure our teams have a focus on clinical supervision.

The current policy in our organisation states that clinical supervision:

'is regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part s/he plays as an individual in the complexities of the events and the quality of practice.'

All clinical staff are expected to record the date they have received supervision and of the content discussed, be able to provide records to evidence that they are in receipt of supervision and managers have a responsibility to ensure that staff have access to and are able to provide evidence of their supervision as part of ongoing appraisal and management supervision.

Using this premise as a focus we undertook an audit of clinical supervision to establish a benchmark position. Summary findings are:

- The practice of accessing clinical supervision is variable across different professional group and teams.
- There is a need to provide clinical supervision training for staff that are required to provide this.
- In some teams a number of staff are not compliant with the Trust standard for frequency of access to clinical supervision.
- It is evident that there is work required to clarify the difference between the requirements and functions of managerial, professional and clinical supervision.

In response to these findings each BDU clinical governance group has been asked to review the findings of the clinical supervision audit and consider the implications for practice. The Clinical Governance and Clinical Safety Committee will receive a summary report with recommendations on how to improve compliance in this area.

3. Staff Friends & Family Test: percentage of scores recommending

The staff Friends & Family test (FFT) was introduced for the first time in April 2014, as part of the national staff FFT implementation by NHS England. The FFT is a simple feedback tool which allows patients and staff to give their feedback on NHS services. The two questions included in the survey for the staff FFT ask for feedback on your recent experience of working here in the form of two questions, both of which include free text comment boxes so that you can add more detail:

> How likely are you to recommend the Trust to friends and family if they needed care or treatment?
>
> How likely are you to recommend the Trust to friends and family as a place to work?

2014 feedback for the Staff FFT and NHS Staff Survey

The results of the Staff FFT for quarters one and two in 2014 are:

1) **Recommending the Trust to friends or family if they needed care or treatment**

The quarter one results show that 19% of staff responding to the survey would be extremely likely to recommend, with 51% likely to recommend, an overall figure of 70% likely to recommend.

The quarter two results show that 16% of staff responding to the survey would be extremely likely to recommend, with 50% likely to recommend, an overall figure of 66% likely to recommend.

2) **Recommending the Trust to friends or family as a place to work**

The quarter one Staff FFT results show that 16% of staff responding to the survey would be extremely likely to recommend, with 46% likely to recommend, an overall figure of 62% likely to recommend.

The quarter two results show that 12% of staff responding to the survey would be extremely likely to recommend, with 44% likely to recommend, an overall figure of 56% likely to recommend.

3.1 NHS Staff Survey feedback 2014

The NHS Staff Survey 2014 results were received in February 2015. Positive feedback included 84% of staff are satisfied with the quality of work and patient care they are able to deliver, which is 8% above the national average and 92% of staff agree that their role makes a difference to patients, which is 4% above the national average. Areas for development were identified as numbers receiving health and safety training, numbers of staff reporting errors, near misses and incidents and communication between senior management and staff.

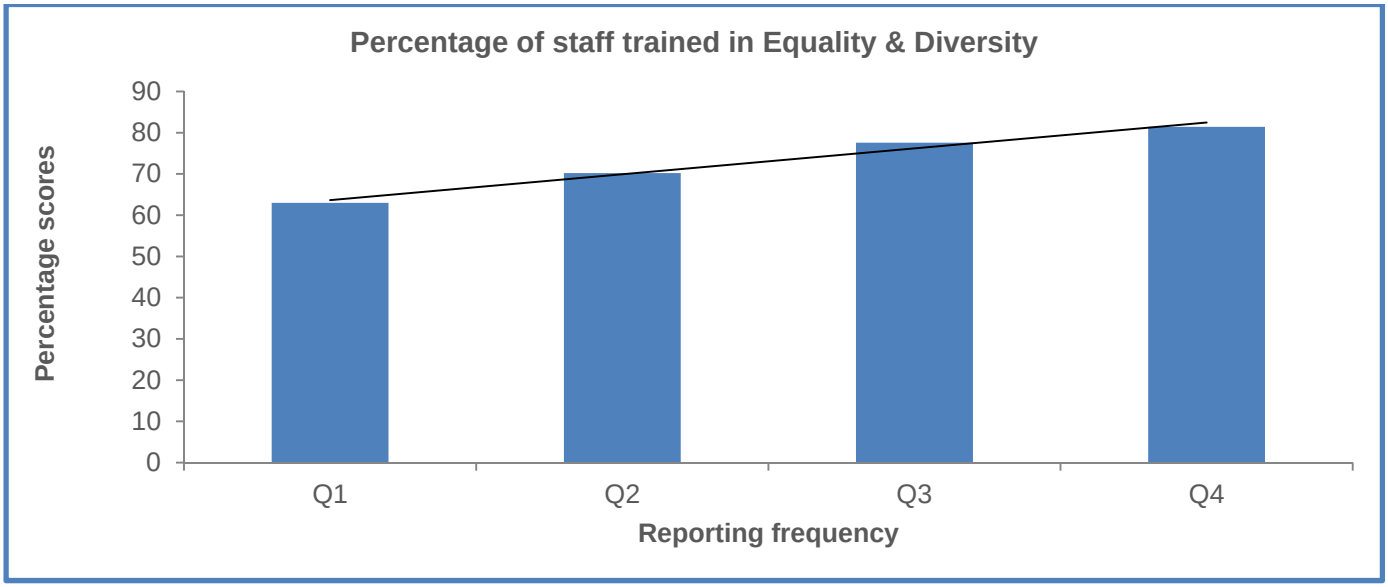
In response to survey feedback the Trust ran a number of engagement groups with staff to share the results and discuss solutions to areas for development.

In response to these findings there have been a range of initiatives introduced to improve the provision of care and to improve staff experience at work. In addition, specific work has been undertaken in areas of service where results identified development needs. This has included the provision of resilience training and targeted development activity.

A significant focus in the last year has been the development of values based employment policies, including recruitment induction and appraisal. Improving staff well-being, resilience and engagement is also a key priority. During 2014 the Trust appointed a head of leadership and management development who has been working with General Managers, Practice Governance Coaches and Clinical Leads to support their development. The Trust is currently developing a values based leadership competency framework.

4. Equality & Diversity training

We monitored the progress made in Equality & Diversity training throughout 2014-15 as this was an area of the national staff survey where we identified we needed to improve. The following chart demonstrates our progress through the year against our goal of 80%.



What next?

Throughout 2015-16 we will continue with our commitment to listen to our staff and act on their feedback.in addition we will endeavour to improve our staff FFT and national staff survey scores and continue to develop our culture where clinical supervision is seen as fundamental to the provision of good quality care. Our partnerships team are currently reviewing the content of the equality and diversity training package and Trust board have planned an Equality and Diversity forum.

Implementation of our leadership and management strategy and staff engagement strategy will be fundamental in assisting us to address the well-being of the workforce.

Priority 7: Improve the safety of our service users, carers, staff and visitors (Safety)

Why did we focus on this?

We want to make sure the people who work with us and visit us are safe from harm.

What progress have we made?

Key Performance Measures 2014-15

We monitored five key performance measures against this quality priority. The table on page 31-33 demonstrates the progress we have made in this area, i.e. that we have achieved all our safety goals, with the exception of the 'reduction in the number of medication errors entered in the 'other' category'. We achieved 80% of our goals in this category.

1. **Implementation of Mental Health Safety Thermometer**

The Mental Health Safety Thermometer (MHST) is a national tool that has been designed to measure commonly occurring harms in people that engage with mental health services. It's a point of care survey that is carried out one day per month which supports improvements in patient care and patient experience, prompts immediate actions and integrates measurement for improvements into daily routines.

Between April and October 2014 SWYPFT participated in the national pilot to implement the MHST toolkit and assisted with reviewing and refining data collection tools prior to them being rolled out nationwide in October 2014.

In SWYFT we have fifty two teams that have participated in the MHST data collection from November 2014 and this will be expanded in 2015 to include our Forensic services. In the Trust we now have sufficient data available to start to use the information in service evaluations and developments. The MHST is designed to measure local improvement over time and is not designed

to compare organisations. We will continue to report on this measure throughout 2015-16 and share the improvements made.

2. Pressure Ulcer reporting

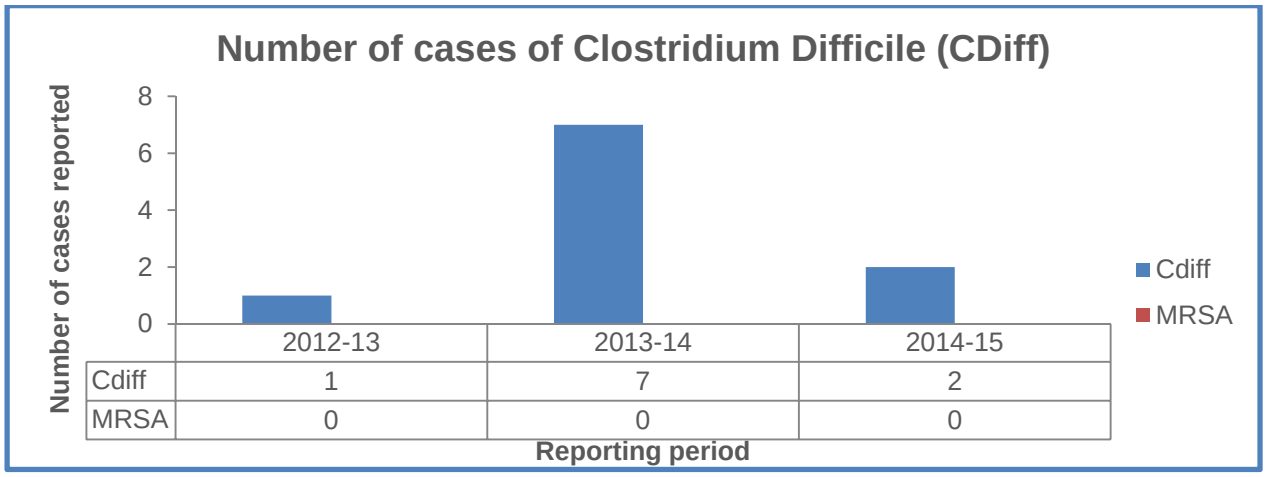
A pressure ulcer is defined as*:*
‘ An area of localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers’.

In 2014-15 we were asked by our clinical commissioning group to monitor the number of pressure ulcers that were ‘avoidable and attributable’ to SWYPT with the aim of reducing these figures across the year. Between April – June (2014) a benchmarking exercise was undertaken. Analysis of the statistics identified that 26 pressure ulcers were attributed to SWYPFT services in the Barnsley BDU in quarter 1. The goal to achieve was less than 26 pressure ulcers that were classified as avoidable and attributable’ to SWYPT.
To address this goal an action plan was developed and implemented across relevant teams.
The year-end total was seven pressure ulcers, meaning we reduced pressure ulcer incidents by more than 75% across the remaining part of the year.

3. Infection rates of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (CDiff).

In our Barnsley services we monitored the infection rates related to MRSA and C Diff as part of our commissioning contract. We did this as these two infections can have serious health consequences and tend to be prevalent in health care environments where individuals tend to be older, sicker and weaker than the general population, which heightens their vulnerability to infection through weakened immunity. In addition healthcare environments involve a great many people living and working together which creates a perfect condition for transferring infections. A simple, but effective way of reducing the spread of infections is by using effective hand washing procedures.

The chart below presents the number of cases we have had of MRSA and CDiff, in SWYPFT since 2012.



	2012-13	2013-14	2014-15
Cdiff	1	7	2
MRSA	0	0	0

The SWYPFT goal for MRSA is that we should have zero cases, which we have achieved consistently across the years shown.

The goal for C Diff is that we should have no more than eight cases per year. Again we have achieved this goal across the years. It is worth noting that Public Health England have reported that with CDiff we have potentially reached an irreducible minimum level at which this infection will occur regardless of the quality of care provided. Their rationale for this statement is that some infections are a consequence of factors outside of the NHS organisations that detect the infection.

In SWYPFT we have maintained the mandatory training goals for infection, prevention and control (including hand washing) during 2014-15.

4. Effective monitoring and response to medication errors

The SWYPFT Incident Reporting and Management Policy states that incidents should be reviewed by managers within 7 working days. This is an important stage of an incident, as it is where a manager confirms the incident record is accurate, ensures appropriate immediate actions have been taken to minimise reoccurrence, and to identify if further investigation is required to ensure lessons are learned.

Following a review of the length of time between an incident being reported and the manager's initial review, it was identified that 59% of incidents (Quarter 2 2014-15) were reviewed within the 7 working day timescale.

This was identified as an issue following a review of the medication incidents in 2013-14 Quality Accounts. In order to improve this, information was circulated to all staff reminding managers that they must ensure they have processes in place to ensure incidents are reviewed within 7 working days. To support this, the Patient Safety Support Team offered managers ongoing support and training. A target was agreed to aim to improve the 59% rate by 5% by the end of Quarter 4.

Monitoring at the end of Quarters 3 and 4 has revealed that the length of time between an incident being reported and the manager's initial review has improved in Quarter 3 and 4. At the end of Quarter 3 the figures was 67%, and at the end of Quarter 4, 66% of incidents were reviewed within 7 working days.

The Quarter 4 timescales monitoring information will be fed back to BDUs via the Incident Management reports. Monitoring will continue to be reviewed at six monthly intervals (Q2 and Q4) and the findings shared with BDUs through routine reporting. The Patient Safety Support Team will continue to support managers with their processes for reviewing incidents and provide training and support where required.

5. Reduction in the number of medication errors entered in the 'other' category.

Analysis of incident reports locally and nationally has allowed new risks to be identified and communicated to healthcare professionals and providers. However, the success of this system depends on the quality of reporting. To fully understand medication errors and incidents, as much information as possible is required. This is not always included in SWYPFT medication incident reports. Incident information may be miscoded and incident reports may be delayed in reaching the National Reporting & Learning System (NRLS). There may be a consequent delay in sharing lessons.

As correct and completed data fields will improve the data quality of medication incidents reported to the NRLS we wanted to undertake a focussed piece of work to support local and national incident management systems. This will allow more detailed assessment, support national analysis of potential safety concerns resulting in regulatory action (if necessary) and enable feedback to healthcare professionals which will support local learning. This will lead to the safer use of medicines and greater protection of public health.

National analysis of the 12,355 medication error incidents reported to the NRLS in March 2013 noted 12% of incidents used “other” in the medication process field (options include prescribing, dispensing administration) and 25% used the term “other” in the medication error type (options included wrong dose, wrong directions, omitted dose).

Locally in the benchmark quarter (Quarter 2 in 2014-15) 28% of incidents were categorised as “other” in the process field and 11% in the “other” for sub category (medication error type).

Quarter (2014-15)	Total incidents	Medication Other category	
Q2	198	56	28%
Q3	204	60	29%
Q4	208	50	24%

During Quarter 4 a bulletin has been produced and circulated via the weekly staff communication email, incidents have been reviewed by the medication safety officer and training sessions have been carried out for pharmacy staff.

The Medication Safety Officer (MSO) is working with the national MSO network to look at categories for incidents within mental health services which was acknowledged as an issue at the recent NHS England Patient Safety conference. One suggestion being that delivery/transportation should be included as a category and locally this would account for many of our “other” categories.

The Medication Safety Officer will continue to link with the patient safety team to review categories and provided feedback to staff.

What next?

In 2015-16 we will monitor progress with service improvements made as a direct result of intelligence from the mental health safety thermometer and focus on initiatives to improve the physical health care of people with mental health and learning disabilities. In addition we have ‘signed up to safety’, and will report the success of this campaign in the 2015-16 quality account report.

Performance against indicators set out in The Risk Assessment Framework (Monitor, 2015)

The table below shows our performance against the indicators we submit to Monitor, as required for our regulation process and as set out in the Risk Assessment Framework.

Indicator	SWYPFT performance data				
	Threshold	Q1	Q2	Q3	Q4
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	98.98%	98.82%	99.33%	99.49%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	98.53%	97.34%	98.36%	98.21%
Care Programme Approach (CPA) patients having formal review within 12 months	95%	96.78%	96.19%	96.33%	98.59%
Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	99.54%	98.55%	100%	99.15%
Meeting commitment to serve new psychosis cases by early intervention teams		186.19%	179.49%	200.84%	182.01%
Mental health data completeness: identifiers	97%	99.41%	99.54%	99.58%	99.59%
Mental health data completeness: outcomes for patients on CPA	50%	84.35%	84.88%	80.04%	80.27%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Compliant	Compliant	Compliant	Compliant
Data completeness: community services (R), comprising:					
referral to treatment information	50%	100%	100%	100%	100%
referral information	50%	94%	94%	94%	94%
treatment activity information	50%	94%	94%	94%	94%

Glossary

A Triangle of Care: a joint framework between the carer's trust and the National mental health Development Unit. It was developed by carers and staff to improve carer engagement on inpatient areas.

AIMS **Accreditation for Inpatient Mental Health Services**: standards for inpatient wards

BDU **Business Delivery Unit:** The Trust runs services on a district by district basis with support from a central core of support services. These district management units are called Business Delivery Units (BDUs). We have six BDUs; Barnsley, Calderdale, Kirklees, Wakefield and Forensics and Specialist Services.

CAMHS **Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.

CMHT **Community mental health team**
A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.

CPA **Care Programme Approach CPA**
CPA is the framework for providing care for mental health service users

CQC **Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. They look at the joined up picture of health and social care. Its aim is to ensure better care for everyone in hospital, in a care home and at home.

CQUIN **Commissioning for Quality and Innovation.** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (the NHS next stage review report) of an NHS where quality is the organising principle.

DATIX Datixweb is the web based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically

DOH **Department of Health**
The Government body responsible for delivering a fast, fair, convenient and high quality health service in England.

DTOC **Delayed transfer of care** – occurs when a patient is ready for transfer from acute care, but is still occupying an acute bed.

FFT **Friends & Family Test:** a patient experience and quality improvement tool used across the NHS.

Information Governance: Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information**.**

Long term conditions: a health problem that cannot be cured but can be controlled by medication or other therapies.

MDT **Multi Disciplinary team (MDT):** A team of professionals drawn from various disciplines that combine their expertise to the benefit of patients

Monitor Monitor is the sector regulator for health services in England and our job is to make the health sector work better for patients

MSO **Medication Safety Officer:** a person responsible for overseeing improvements related to medication

NICE **National Institute for Clinical Excellence:** a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money

NHS England NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.[1] It holds the contracts for GPs and NHS dentists.

OPS **Older peoples services –** services for people over the age of 65.

PICU **Psychiatric Intensive Care Unit –** an adult mental health inpatient ward that provides intensive care for people with mental health problems.

POMH **Prescribing Observatory for Mental Health.** The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice

RiO The electronic patient record system that is used in mental health services

SPA **Single Point of Access (SPA):** One place where all referrals - a request for extra help for an individual – are received. The SPA is run by very experienced nursing, medical, and social care staff who look at each referral.

Annexes

Annex 1: Statements from our stakeholders

1. Wakefield Overview & scrutiny Committee

South West Yorkshire Partnership NHS Foundation Trust

Through the Quality Accounts process the Adults and Health Overview and Scrutiny Committee have engaged with the Trust to review and identify quality themes and the Trust has sought the views of the Overview and Scrutiny Committee with the opportunity to provide pertinent feedback and comments.

The committee agrees with the Trust's seven quality priorities and believes a consistent approach is useful to underpin the quality measures against which improvement can be measured. The Committee is assured that the identified priorities are in concert with those of the public and that these have been developed through wide consultation with service users and the public in the production of the Quality Account.

Members firmly believe that listening to and acting on service user feedback is an effective means by which to improve services. The Trust's organisational focus on customer service underpins this approach. The Committee also supports the development of real time feedback for capturing and acting on patient experience.

The Committee welcomes the decision of the Trust to stretch targets where appropriate in order to sustain continued improvement with measures higher than the goals set by commissioners.

The Committee has focused on staff engagement as part of its current work programme and is pleased to see encouraging results from the 2014 NHS Staff Survey. There is compelling evidence that highly engaged employees have fewer accidents, make better use of resources and deliver better financial performance. In addition, highly engaged employees are more likely to deliver high-quality care, are healthier and happier, with lower sickness rates and lower staff turnover - all of which will effectively contribute to the Trust's quality goals.

The Committee notes the commitment to carers in the Quality Account and welcomes the Trust's recognition of carers as partners in care. Members recognise the work being undertaken by the Trust to improve the experience of carers.

The Committee supports the decision to revise the performance measure in relation to care plans. The emphasis on quality is welcome with a clear focus on co-production and personalised planning.

The Committee has engaged with the Trust in relation to the ongoing service transformation programme and shares the view that the organisation focus on transformation activity may lead to a lack of attention to quality within day-to-day delivery of services. Members therefore welcome the Trust's actions in mitigating this risk.

The Committee shares the concerns about the speed in which people can access the Trust's services, particularly in secondary mental health care and child and adolescent mental health services (CAMHS). Members welcome the introduction of a mental health liaison service into all acute general hospitals which allows early intervention and help when people are in distress.

The Committee has reviewed the Mental Health Crisis Concordat and particularly supports the commitment of access to support before crisis point – making sure people with a mental health problem can get help 24 hours a day and that when they ask for help, they are taken seriously. The Committee is currently looking at the quality of treatment and care when in crisis – making sure that a mental health crisis is treated with dignity and respect, in a therapeutic environment. The Committee remains concerned regarding the use of police cells as places of safety for people who are detained under Section 136 of the Mental Health Act and therefore welcome the statement in the Quality Account of all partners working together for local benefit.

Patient safety has been a particular focus for the Committee over the last 12 months and Members have considered the number and percentage of patient safety incidents across the Trust that has resulted in severe harm or death. The number of severe harm or death incidents seems relatively high with 51 deaths reported over the last year. Although not a specific requirement of the Quality Account reporting process, the Committee would like to see some comparative information in the Quality Account as a means of setting these figures in context. Without such information local people may struggle to understand whether a particular number is better or worse than comparable Trusts.

Overall the Committee believes the layout and content of the Quality Account provides relevance and clarity to both a professional and public audience.

The Committee is grateful for the opportunity to comment on the Quality Account and looks forward to working with the Trust in reviewing performance against the quality indicators over the coming year.

2. Calderdale, Kirklees and Wakefield CCG

Dear Tim

South West Yorkshire Partnership Foundation Trust Quality Accounts Feedback 2014/15

We were pleased to receive and comment on the Quality Account prepared by South West Yorkshire Partnership Foundation Trust (SWYPFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG, NHS Calderdale CCG, NHS North Kirklees CCG and NHS Wakefield CCG.

To the best of our knowledge we believe that the information provided is accurate and has been fairly interpreted. The quality account provides a balanced summary of the quality of service measured over the course of the previous year with good organisational context for how this is managed and the Trust's quality ambitions.

We are pleased that the Trust has attained a high number of quality standards. The Trust is open about the areas of underachievement in 2014/15 and has increased the target into some longer term standards which were being met previously.

We were pleased to see, in the Statement from the Chair and CEO, a reference to both the new Duty of Candour and the Safer Staffing Initiative. We commend the work that the trust has undertaken to develop a staffing level tool that allows staffing levels to be reassessed and set at the correct level.

As commissioners we have welcomed the opportunity to be involved in the 15 steps programme within the Trust and look forward to ongoing participation with this. This would have been strengthened with some inclusion of the findings and actions agreed to improve the experience of service users on inpatient wards. We are pleased to see commitment to “sign up to safety” and continued participation in the mental health safety thermometer.

Within the Key Performance Measures 2014/15 we note that there are some significantly differing results on both access to services and the Friends and Family test for Adult Mental Health Services and CAMHS depending on locality. For both services it is noted that results were worse in Calderdale and Kirklees than Wakefield or Barnsley. The Trust has identified these differences and put forward some improvement plans and we will be interested to see the impact of these within this business delivery unit as a result of these.

It was disappointing to see that the report indicates that only one NICE clinical quality standard had been reviewed during the year, and there is no ambition for this work to be continued into 2015/16.

We would have expected to see further detail relating to the challenges within the Calderdale and Kirklees CAMHs service and feel that the narrative does not fully reflect these.

We support the continuation of the 7 priority areas and are particularly pleased to see the following priorities:

Priority 2: Access to care. We continue to have feedback from patients and GP referrers about difficulties accessing the Trust’s services, so welcome access to care as a continued priority. This feedback is shared directly with the Trust, and we will continue to closely monitor access targets, and share experience feedback from our quality intelligence process

Priority 3: Improving Care and Care Planning. A focus on improving the quality of care plans as a key measure for this priority is welcomed, and one of the local Commissioning for Quality and Innovation indicators agreed for this year gives the Trust a contractual incentive to achieve this. We are also pleased that learning disability services are developing outcomes to measure effectiveness of service delivery and acknowledge the challenges in achieving this.

Priority 4: Record Keeping and Data Quality. We are pleased to see that record keeping and data quality remains a high priority for 2015/16 with plans in place to address improvement in this area.

These continue to be challenging areas and we welcome the strengthening of the clinical, managerial and quality leadership within each business development unit as a platform to achieve progress within these priorities.

We look forward to continuing to work closely with the Trust over the coming year in order support the Trust in achieving the quality improvement priorities set out in the account.

Yours sincerely

Penny Woodhead

Head of Quality and Safety

Chair of SWYPFT Quality Board

On behalf of NHS Calderdale CCG, NHS Greater Huddersfield CCG, NHS North Kirklees CCG & NHS Wakefield CCG

3. Barnsley Clinical Commissioning Group

Re: SWYFPT Quality Account 2014/15

Thank you for sending through the Trust's Quality Account 2015/15 for our comments. The CCG welcomes the report which provides an overview of the work and initiatives undertaken throughout the year. Overall we found the account to be concise and clearly presented.

The Account has been sent to our Quality & Patient Safety Committee members for their consideration and we have collated the following comments below which we hope you will find helpful.

- Whilst recognising the geography SWYPFT services cover, we were pleased to see the increased visibility of Barnsley services in the evidence provided within the Account.
- We found it very useful to see the benchmarking between the different Business Delivery Units in order to identify whether patients are receiving the same quality of services across the Trust.
- We were pleased to see the highlighted work required with CAMHS access in 2015/16 and welcome the appointment of a dedicated Service Director.
- Commissioners have found it helpful to see the work on Safer Staffing and appreciate the communication to the CCG's Chief Nurse and Contract Team. We look forward to this continuing with the new monitoring tool.
- As part of the quality priorities, Commissioners would want to see specific sight of Barnsley BDU serious incidents reported. Whilst we commend the reduction in Pressure Sores, we seek further improvement in the risk assessment skills of District Nurses to ensure maximum prevention strategies adopted.
- We acknowledge the figures reported against the shared electronic records and Commissioners reflect your concerns. We will work with you to try to resolve the issues.
- We commend the work carried out by the Infection Control Team on pages 53/54 to reduce HCAI. The work that the team has undertaken in relation to the Post Infection Reviews has improved the standard of reporting and discussions with Clinicians in Primary Care have been very beneficial.

We hope you find our comments useful and look forward to working with you over the next year.

Yours sincerely

Brigid Reid
Chief Nurse

Annex 2: Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2014 to 22nd May 2015
  - papers relating to Quality reported to the board over the period April 2014 to 22nd May 2015
  - feedback from commissioners dated 19.5.2015 & 20.5. 2015
  - feedback from local Health watch organisations dated 20.5.2015
  - feedback from Overview and Scrutiny Committee dated 19.5.2015
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2014 (Q1), Oct 2014 (Q2), Dec 2015 (Q3) and March 2015 (Q4).
  - The national community mental health patient survey 2014
  - The national staff survey 2014
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 22.5.2015
  - CQC Intelligent Monitoring Report dated November 2014.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data

quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

NB: sign and date in any colour ink except black

22 May 2015.....Date.....  .....Chair

22 May 2015.....Date.....  .....Chief Executive

Data entered below will be used throughout the workbook:

Trust name:	South West Yorkshire Partnership NHS Foundation Trust
This year	2014/15
Last year	2013/14
This year ended	31 March 2015
Last year ended	31 March 2014
This year commencing:	1 April 2014

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South West Yorkshire Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed…….
Steven Michael Chief Executive Date 22 May

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent; and

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed.....
Steven Michael Chief Executive Date 22 May 2015

Signed.....
Alex Farrell Director of Finance Date 22 May 2015

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

Opinion on the financial statements of South West Yorkshire Partnership NHS Foundation Trust	In our opinion the financial statements: •give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2015 and of the Group's and Trust's income and expenditure for the year then ended; •have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and •have been prepared in accordance with the requirements of the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cashflows and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate	We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Going concern	We have reviewed the Accounting Officer's statement contained on page 83 that the Group is a going concern. We confirm that •we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and •we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS COUNCIL AND BOARD OF DIRECTORS OF SOUTH WEST

Our assessment of risks of material misstatement	The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.**:**
Recognition of NHS revenue This risk is focussed upon incremental adjustments to the Trust's revenue contracts arising during the year. The risk particularly arises where there are elements of judgement as to whether, and the extent to which, revenue should be allocated to the current or future accounting periods depending, for example, upon the performance obligations included in the contract for services. Incremental adjustments resulted in changes to the income budget for 2014/15 of £0.04m, income for the year is disclosed in note 5 to the financial statements.	·We reviewed management's controls governing the acceptance of incremental adjustments testing the design and implementation of these controls. ·We examined a sample of incremental adjustments to determine whether valid contract documentation existed and challenged the allocation of revenue to accounting periods.
Property valuations The Trust holds property assets of £100.3m within Property, Plant and Equipment at a modern equivalent asset valuation. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. The financial statements, at note 12 reflect £2.1m of revaluation gains experienced in the year, along with £1.8m impairments noted and charged to the operating surplus.	•We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. •We used our internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties with reference to our observations and experience at other similar organisations. •We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, as adapted for public sector bodies, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Accounting for capital expenditure The Trust has a significant capital investment programme of £19.1m over the next two financial years. In 2014/15 the Trust spent c£6.1m of capital including £2.6m on the Community Hubs (e.g. Laura Mitchell House, New Street refurbishment, acquisition and refurbishment of estate within Wakefield). Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards, and when to commence depreciation . In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down. Where existing properties are being modernised, the "modern equivalent asset" valuation rules can lead to a "day one" impairment where the accumulated cost of the asset exceeds the cost of a newly built facility. During the year the Trust recognised £1.5m of expenditure on assets under construction details of which can be found in note 14.1 to the financial statements.	·We reviewed management's controls concerning the valuation of assets following completion of construction works and the accumulation of costs into assets under construction at the year end and tested the design and implementation of these controls. ·We tested, on a sample basis, the accumulation of cost into the balance of assets under construction. ·We obtained and tested management's calculation of the impairment to the value of assets under construction at the year end and used our internal valuation specialists to review and challenge key assumptions. ·We reviewed the transfer of assets from "Assets under construction" to operational assets and tested the recognition of depreciation following the transfer. ·We tested the completeness and transparency of the disclosure in the notes to the financial statements.
	The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on pages 40 and 41 of annual report. Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

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

Our application of materiality	We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work. We determined materiality for the Group to be £2.3m (2014: £2.3m). This is below 1% of Operating income from continuing operations and below 2% of Taxpayers' Equity (2014 : 1% and 2% respectively). Our determination of materiality was based upon Operating Income from Continuing Activities as, in our judgment, this represented the most accurate measure of the scale of the Group. We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £117k (2014: £116k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit	Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level. The focus of our audit work was on the Trust, with work performed at the Trust's offices in Castleford directly by the audit engagement team, led by the audit partner. The group comprises two components, the Foundation Trust (which represents 99.97% of the group when measured by Operating Income and 99.56% when measured by Total Assets Employed) and the Charitable Funds (which represent the remainder). The Trust's subsidiary charity was subject to independent examination by the audit team. Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances. The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems .

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

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

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

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

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

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

Paul Thomson, ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK
27 May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2015

		Group		Trust	
		Year Ended 31 March 2015	Year Ended 31 March 2014	Year Ended 31 March 2015	Year Ended 31 March 2014
	note	£000	£000	£000	£000
Operating Income from continuing operations	5	237,742	235,755	237,677	235,446
Operating Expenses of continuing operations	6	(232,223)	(230,626)	(231,883)	(230,253)
Operating surplus / (deficit)		**5,519**	**5,129**	**5,794**	**5,193**
Finance costs:					
Finance income	10	97	93	95	88
PDC Dividends payable		(2,793)	(1,529)	(2,793)	(1,529)
NET FINANCE COSTS		**(2,696)**	**(1,436)**	**(2,698)**	**(1,441)**
Movement in fair value of investment property and other investments	15	16	0	16	0
SURPLUS/(DEFICIT) FOR THE YEAR		**2,839**	**3,693**	**3,112**	**3,752**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Gain/(loss) from transfer by absorption from demising bodies		0	35,741	0	35,741
Impairments		0	(3,518)	0	(3,518)
Revaluations		2,098	0	2,098	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**4,937**	**35,916**	**5,210**	**35,975**

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

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

STATEMENT OF FINANCIAL POSITION	note	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
Non-current assets					
Intangible assets	13	552	773	552	773
Property, plant and equipment	14	105,757	102,608	105,757	102,608
Investment Property	15	340	410	340	410
Total non-current assets		**106,649**	**103,791**	**106,649**	**103,791**
Current assets					
Inventories	19	204	282	204	282
Trade and other receivables	20	7,956	7,022	7,978	6,771
Cash and cash equivalents	21	33,159	33,655	32,617	33,114
Total current assets		**41,319**	**40,959**	**40,799**	**40,167**
Current liabilities					
Trade and other payables	22	(20,578)	(23,194)	(20,577)	(23,194)
Provisions	24	(3,781)	(3,507)	(3,781)	(3,507)
Other liabilities	22	(751)	(843)	(751)	(843)
Total current liabilities		**(25,110)**	**(27,544)**	**(25,109)**	**(27,544)**
Total assets less current liabilities		**122,858**	**117,206**	**122,339**	**116,414**
Non-current liabilities					
Provisions	24	(4,323)	(3,703)	(4,323)	(3,703)
Total non-current liabilities		**(4,323)**	**(3,703)**	**(4,323)**	**(3,703)**
Total assets employed		**118,535**	**113,503**	**118,016**	**112,711**
Financed by					
Taxpayers' equity					
Public Dividend Capital		43,492	43,397	43,492	43,397
Revaluation reserve	26	16,781	14,785	16,781	14,785
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		52,523	49,309	52,523	49,309
Others' equity					
Charitable fund reserves		519	792	0	0
Total taxpayers' and others' equity		**118,535**	**113,503**	**118,016**	**112,711**

The financial statements on pages 2 to 40 were approved by the Board of Directors and authorised for issue on the 22 May 2015 and signed on their behalf by:

.....Steven Michael, Chief Executive 22.5.15 .....Date

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	**Trust Total**	Charity Reserve	**Group Total**
	£000	£000	£000	£000	**£000**	£000	**£000**
At 1 April 2014	43,397	14,785	5,220	49,309	112,711	792	113,503
Surplus for the year	0	0	0	3,112	3,112	(273)	2,839
Revaluations - property, plant and equipment	0	2,098	0	0	2,098	0	2,098
Public dividend capital received	95	0	0	0	95	0	95
Other reserve movements	0	(102)	0	102	0	0	0
Taxpayers' Equity at 31 March 2015	**43,492**	**16,781**	**5,220**	**52,523**	**118,016**	**519**	**118,535**

	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	**Trust Total**	Charity Reserve	**Group Total**
	£000	£000	£000	£000	**£000**	£000	**£000**
At 1 April 2013	41,991	7,261	5,220	20,858	75,330	851	76,181
Surplus for the year	0	0	0	3,752	3,752	(59)	3,693
Transfers by Modified absorption : transfers between reserves	0	11,042	0	(11,042)	0	0	0
Transfers by Modified absorption : Gains/(losses) on 1 April transfers from demising bodies (NHS Barnsley)	0	0	0	35,741	35,741	0	35,741
PDC adjustment for cash impact of payables/receivables transferred from legacy teams	1,406	0	0	0	1,406	0	1,406
Impairments	0	(3,518)	0	0	(3,518)	0	(3,518)
Taxpayers' Equity at 31 March 2014	**43,397**	**14,785**	**5,220**	**49,309**	**112,711**	**792**	**113,503**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2015		Group		Trust	
		Year Ended 31 March 2015	Year Ended 31 March 2014	Year Ended 31 March 2015	Year Ended 31 March 2014
	note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		5,519	5,129	5,794	5,193
Operating surplus/(deficit)		**5,519**	**5,129**	**5,794**	**5,193**
Non-cash income and expense:					
Depreciation and amortisation	6	5,177	5,144	5,177	5,144
Impairments	6	1,802	5,085	1,802	5,085
Reversal of Impairments	5	(2,092)	(2,252)	(2,092)	(2,252)
(Gain)/Loss on Disposal	6	97	0	97	0
(Increase)/Decrease in Trade and Other Receivables	20	(1,189)	(2,193)	(1,207)	(2,192)
(Increase)/Decrease in Inventories	19	78	278	78	278
Increase/(Decrease) in Trade and Other Payables	22	(627)	1,495	(627)	1,494
Increase/(Decrease) in Other Liabilities	22	(92)	57	(92)	57
Increase/(Decrease) in Provisions	24	894	(860)	894	(860)
Movements in operating cash flow in respect of Transforming Community Services transaction		0	(1,573)	0	(1,573)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		256	(255)	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**9,823**	**10,055**	**9,824**	**10,374**
Cash flows from investing activities					
Interest received		95	93	95	88
Purchase of intangible assets		(10)	(413)	(10)	(413)
Purchase of Property, Plant and Equipment		(8,148)	(6,814)	(8,148)	(6,814)
Sale of property, plant and equipment and Investment Property		401	0	401	0
NHS Charitable Funds - net cash flows from investing activities		2	0	0	0
Net cash generated from/(used in) investing activities		**(7,660)**	**(7,134)**	**(7,662)**	**(7,139)**
Cash flows from financing activities					
Public dividend capital received		95	0	95	0
Public dividend capital received (PDC adjustment for modified absorption transfers of payables/receivables)		0	1,406	0	1,406
PDC Dividend paid		(2,754)	(1,382)	(2,754)	(1,382)
Net cash generated from/(used in) financing activities		**(2,659)**	**24**	**(2,659)**	**24**
Increase/(decrease) in cash and cash equivalents		**(496)**	**2,945**	**(497)**	**3,259**
Cash and Cash equivalents at 1 April		33,655	30,710	33,114	29,855
Cash and Cash equivalents at 31 March		**33,159**	**33,655**	**32,617**	**33,114**

Notes to the Accounts - 1. Accounting Policies

1 Accounting Policies

Monitor (the sector regulator for health services in England) has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which is agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014 / 2015 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust applies estimates for the pension provision and injury provision based on average life expectancy.

The holiday pay accrual is based on an actual data collection at 31/03/15. A sample of 10% of the workforce was taken on their outstanding leave and applied across the Trust to calculate the accrual.

The redundancy provision is based on detailed working papers and review as linked to the Trust Annual Plan and Cost Improvement Programme (CIP).

The estimate of income arising from the achievement of Trust Commissioning for Quality and Innovation (CQUIN) targets are based upon current performance information and discussions with Commissioners.

The value of property plant and equipment is reviewed each year by an appropriately qualified independent party. Based upon this review the Trust considered whether or not there is evidence that a material change in valuation has occurred and, in which case, the movement is recognised within the Trust Accounts. The Trust estate was revalued by the District Valuer as at 31st December 2014 and as a result the revaluation was recognised in these accounts.

The Trust discloses the critical judgements made by the Trust's management as required by IAS 1.122. (Presentation of Financial Statements).

1.3.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

For 2014 / 2015 no key assumptions have been made, or are required, as to future estimation uncertainty further than those already declared in their separate notes.

Information about the key assumptions for the Trust is disclosed, as required by IAS 1.125 (Presentation of Financial Statements). Disclosures include the nature of the assumption and the carrying amount of the asset/liability at the end of the reporting period and may include sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year, and an explanation of changes to past assumptions if the uncertainty remains unresolved.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Revenue (Income)

The main source of revenue (income) for the Trust is from Clinical Commissioning Groups (CCGs), which are government funded commissioners of NHS health and patient care. Revenue is recognised in the period in which services are provided and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Income from the sale of non current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying liabilities. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of these goods and services.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Notes to the Accounts - 1. Accounting Policies (Continued)

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

During 2014 / 2015 the periodic revaluation of estate has been completed by the District Valuer. This was a desktop exercise with the exception of any buildings with material works completed since 2013/14.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 (Borrowing Costs) for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other Expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Revaluation Gains and Losses

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Impairments

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

Notes to the Accounts - 1. Accounting Policies (Continued)

Derecognition (Non-current assets held for sale)

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, an active programme has begun to find a buyer and complete the sale, the asset is being actively marketed at a reasonable price, which is expected to qualify for recognition as a completed sale within one year from the date of classification and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists, research and similar items are not capitalised as intangible assets.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Notes to the Accounts - 1. Accounting Policies (Continued)

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets, other than software licences, are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. Software licences are carried at depreciated historic cost.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Investment Property
Trust property, classed as Investment Property under IAS 40 (Investment Property), is valued at fair value (being current market value). These assets are revalued annually with any gain / losses actioned through the Statement of Comprehensive Income.

1.10 Borrowing Costs
Borrowing costs are recognised as expenses as they are incurred.

1.11 Donated, government grant and other grant funded assets
The Trust currently does not have any donated, government grant or other grant funded assets.

1.12 Government grants
Government grants are grants from government bodies other than revenue from commissioners or NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate.

1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The Trust currently has no finance leases. All other leases are classified as operating leases.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. These separate components are assessed as to whether they are operating or finance leases.

Notes to the Accounts - 1. Accounting Policies (Continued)

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out (FIFO) cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of inventory.

1.15 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation, of uncertain timing or amount, as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.30% in real terms for voluntary early retirement and injury benefit and 2.2% in real terms, for the remaining provisions.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in the notes to the accounts (Note 24) but is not recognised in the Trust's accounts.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.19 EU Emissions Trading Scheme

The Trust is not a member of the EU Emission Trading Scheme in 2014 / 2015.

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.
The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.
They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Notes to the Accounts - 1. Accounting Policies (Continued)

Impairment of financial assets

At the Statement of Financial Position date, The Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The Trust assess financial assets (Non NHS debtors) beyond their due date and, as appropriate, provide for these through the use of the bad debt provision. Any financial asset deemed irrecoverable and not already provided for is written down directly.

1.22 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 Foreign Exchange

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 21 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 (Financial Instruments: Presentation).

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

In 2013/14 a dispensation was given to exclude net assets & liabilities transferred from bodies which ceased to exist on 1st April 2013.

1.26 Taxpayers Equity - Other Reserve

The Other Reserve within tax payers equity was created as part of the Trust's predecessor organisation, South West Yorkshire Mental Health NHS Trust, in 2002. This has remained following authorisation of South West Yorkshire Partnership NHS Foundation Trust in 2009 by Monitor.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

Details of losses and special payments are given in note 35 to the accounts.

1.28 Consolidation

NHS Charitable Fund

The Trust is the corporate trustee to South West Yorkshire Partnership Foundation Trust and Other Related Charities. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14 the Foundation Trust Annual Reporting Manual (FT ARM) permitted the Trust not to consolidate the charitable fund. From 2013/14, the Trust has consolidated the charitable fund which was treated as a change in accounting policy with consequent prior period adjustments in the financial statements for the year ended 31 March 2014. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Subsidiaries, Associates, Joint Ventures and Joint Operations

The Trust has a single subsidiary, the NHS Charitable Fund, as described above and has entered into no other arrangements which give rise to associates, joint ventures or joint operations.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Accounting standards and amendments issued but not yet adopted

The following standards and updates have been published by the International Accounting Standards Board but are not required to be followed until after the current reporting period.

IAS 19 Employee Benefits - amendment - effective 2015 / 2016

IAS 36 Impairment of Assets - amendment - to be adopted from 2015 / 2016

IFRS 9 Financial Instruments - not yet EU adopted, expected to be effective from 2018 / 2019

IFRS 13 Fair Value Measurement - effective 2013 / 2014 but not yet adopted by HM Treasury

IFRS 15 Revenue from contracts with customers - not yet EU adopted, expected to be effective from 2017 / 2018

The Trust is assessing the impact of these standards and updates.

1.30 Transfers of financial assets

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. In 2013/2014 the net gain corresponding to the net assets transferred from Barnsley PCT is recognised within the income and expenditure reserve under the principles of modified absorption accounting which applied to transfers where the transferring body ceased to exist on 1 April 2013.

For property, plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation / Amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

A summary of the Transfer is shown in Note 14.2 below the Property, plant and equipment note.

1.31 Going Concern

These accounts are prepared on a going concern basis (Note 36). The detail behind this assumption is included in the notes to the accounts.

2. Pooled budget

The Group & Trust has no pooled budgets.

3. Operating segments

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

4. Income generation activities

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

5 OPERATING INCOME	**Group & Trust**	
5.1 Income from activities comprises	**Year Ended 31 March 2015 Total £000**	**Year Ended 31 March 2014 Total £000**
NHS Foundation Trusts	362	129
NHS Trusts	0	0
CCGs and NHS England	197,073	195,449
Local Authorities	22,611	23,140
Department of Health - other	0	0
NHS Other	88	127
Non NHS: Other	1,093	1,248
Total income from activities	**221,227**	**220,093**

	Group & Trust	
5.2 Analysis of income from activities	**Year Ended 31 March 2015 Total £000**	**Year Ended 31 March 2014 Total £000**
Block Contract income - Mental Health Services	159,708	138,209
Income from CCGs & NHS England - Community Services	45,104	66,478
Income not from CCG's, NHS England or PCTs - Community Services	15,543	14,399
Other non-protected clinical income	872	1,007
Total income from activities	**221,227**	**220,093**

5.3 Other Operating Income	**Note**	**Group Year Ended 31 March 2015 Total £000**	**Group Year Ended 31 March 2014 Total £000**	**Trust Year Ended 31 March 2015 Total £000**	**Trust Year Ended 31 March 2014 Total £000**
Other operating income					
Research and development		160	237	160	237
Education and training		2,915	3,011	2,915	3,011
Other		8,037	7,048	8,037	7,048
Reversal of impairments of property, plant and equipment	12	2,092	2,252	2,092	2,252
Income in respect of staff costs where accounted for on a gross basis		3,246	2,805	3,246	2,805
NHS Charitable Funds : Incoming Resources excluding investment income		65	309	0	0
Total other operating income		**16,515**	**15,662**	**16,450**	**15,353**
Total Operating Income		**237,742**	**235,755**	**237,677**	**235,446**

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

5.4 Income from activites from Commissioner Requested Services and all other services	**Group Year Ended 31 March 2015 Total £000**	**Group Year Ended 31 March 2014 Total £000**	**Trust Year Ended 31 March 2015 Total £000**	**Trust Year Ended 31 March 2014 Total £000**
Income from Commissioner Requested Services	221,227	220,093	221,227	220,093
Income from non-Commissioner Requested Services	16,515	15,662	16,450	15,353
Total Income	**237,742**	**235,755**	**237,677**	**235,446**

5.5 Operating lease income

The Group & Trust earned no income from operating leases in 2014/15 or in 2013/14.

6 Operating Expenses

6.1 Operating Expenses

	Note	Group Year Ended 31 March 2015 £000	Group Year Ended 31 March 2014 £000	Trust Year Ended 31 March 2015 £000	Trust Year Ended 31 March 2014 £000
Services from NHS Foundation Trusts		119	191	119	191
Services from NHS Trusts		110	0	110	0
Services from CCGs and NHS England		344	0	344	0
Purchase of healthcare from non NHS bodies		4,021	4,153	4,021	4,153
Employee Expenses - Executive directors		1,434	1,105	1,434	1,105
Employee Expenses - Non-executive directors		131	126	131	126
Employee Expenses - Staff		169,778	168,799	169,778	168,799
NHS Charitable funds - employee expenses		31	32	0	0
Supplies and services - clinical (excluding drug costs)		3,725	3,475	3,725	3,475
Supplies and services - general		4,169	4,272	4,169	4,272
Establishment		6,665	7,110	6,665	7,110
Transport (Business travel only)		177	168	177	168
Transport (other)		766	909	766	909
Premises - Business rates payable to Local Authorities		1,463	1,129	1,463	1,129
Premises - other		12,319	9,349	12,319	9,349
Increase / (decrease) in provision for impairment of receivables		(103)	150	(103)	150
Increase in other provisions		0	0	0	0
Change in provisions discount rate		66	53	66	53
Inventories written down (net, including inventory drugs)		0	0	0	0
Drug Costs (non inventory drugs only)		1,504	1,457	1,504	1,457
Inventories consumed (excluding drugs)		290	486	290	486
Drug Inventories consumed		2,768	2,649	2,768	2,649
Rentals under operating leases - minimum lease payments		7,026	7,103	7,026	7,103
Depreciation on property, plant and equipment		4,946	4,968	4,946	4,968
Amortisation on intangible assets		231	177	231	177
Impairments of property, plant and equipment	12	1,802	5,085	1,802	5,085
Audit services- statutory audit		65	65	65	65
Audit services - charitable fund accounts		2	2	0	0
Other auditor remuneration	6.2	30	94	30	94
Clinical negligence - amounts payable to the NHSLA (premiums)		275	283	275	283
Loss on disposal of land and buildings		97	0	97	0
Loss on disposal of other property, plant and equipment		0	0	0	0
Legal fees		147	302	147	302
Consultancy costs		1,741	878	1,741	878
Training, courses and conferences		738	950	738	950
Patient travel		30	42	30	42
Car parking & Security		6	7	6	7
Redundancy		3,028	1,785	3,028	1,785
Early retirements		44	42	44	42
Hospitality		74	102	74	102
Publishing		67	96	67	96
Insurance		311	305	311	305
Other services, eg external payroll		0	1	0	1
Losses, ex gratia & special payments		4	5	4	5
Other		1,475	2,382	1,475	2,382
NHS Charitable funds: Other resources expended		307	371	0	0
Total Operating Expenses		**232,223**	**230,658**	**231,883**	**230,253**

6.2 Other Audit Remuneration	Group & Trust	
	Year Ended 31 March 2015	Year Ended 31 March 2014
Other auditor remuneration paid to the external auditor is analysed as follows:		
1. The auditing of accounts of any associate of the Trust	0	0
2. Audit-related assurance services	0	0
3. Taxation compliance services	0	0
4. All raxation advisory services not falling within item 3 above;	0	0
5. Internal audit services (only those payable to the external auditor)	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. All other non-audit services not falling within items 2 to 7 above	30	94
Total	**30**	**94**

6.3 Auditor Liability

There is no limitation on the Auditor's Liability in 2014/15 or in 2013/14.

6.4 The late payment of commercial debts (interest) Act 1998

The Group & Trust has no late payments of commercial debts in 2014/15 or in 2013/14.

6.5 Discontinued operations

The Group & Trust has no discontinued operations during the period.

6.6 Corporation Tax

The Group & Trust has no Corporation Tax expense during the period.

7. Employee costs and numbers

7.1 Employee costs	Group Year Ended 31 March 2015			Trust Year Ended 31 March 2015		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	140,638	130,116	10,522	140,638	130,116	10,522
Social Security Costs	9,248	8,425	823	9,248	8,425	823
Pension costs - defined contribution plans employers contributions to NHS Pensions	16,510	15,667	843	16,510	15,667	843
Termination benefits	3,028	3,028	0	3,028	3,028	0
Agency/contract staff	5,020	0	5,020	5,020	0	5,020
NHS charitable funds staff	31	0	31	0	0	0
Employee benefits expense	**174,475**	**157,236**	**17,239**	**174,444**	**157,236**	**17,208**
Of which are capitalised as part of assets	204	204	0	204	204	0
Total Employee benefits excl. capitalised costs	**174,271**	**157,032**	**17,239**	**174,240**	**157,032**	**17,208**

	Group Year Ended 31 March 2014			Trust Year Ended 31 March 2014		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	140,190	125,890	14,300	140,190	125,890	14,300
Social Security Costs	9,524	8,608	916	9,524	8,608	916
Pension costs - defined contribution plans employers contributions to NHS Pensions	16,711	15,736	975	16,711	15,736	975
Termination benefits	1,785	1,785	0	1,785	1,785	0
Agency/contract staff	3,685	0	3,685	3,685	0	3,685
NHS charitable funds staff	32	0	32	0	0	0
Employee benefits expense	**171,927**	**152,019**	**19,876**	**171,895**	**152,019**	**19,876**
Of which are capitalised as part of assets	206	206	0	206	206	0
Total Employee benefits excl. capitalised costs	**171,721**	**151,813**	**19,876**	**171,689**	**151,813**	**19,876**

The Board has approved a cost saving programme which resulted in 31 posts being made redundant in 2014/15. The Trust has an identified a cost saving programme for 2015/16 and the impact of this includes the potential redundancy impact of 127 posts and a further in 51 relating to 2016/17. The total redundancy cost provided for in 2014/15 is£5,175k (£3,740k in 2013/14). (See note 24)

As included within the salaries and wages information above, the Trust made payments in 2014/15 of greater than £100k to the following staff groups:

	Year Ended 31 March 2015	Year Ended 31 March 2014
Medical Consultant	57	55
Middle Grade Doctor	8	6
Director / Chief Executive	8	7
Total	**73**	**68**

7. Employee costs and numbers (continued)

7.2 Average number of people employed

	Group			Trust		
	Year Ended 31 March 2015			Year Ended 31 March 2015		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	162	131	31	216	178	38
Administration and estates	917	848	69	983	918	65
Healthcare assistants and other support staff	1,048	1,011	37	991	956	35
Nursing, midwifery and health visiting staff	1,420	1,393	27	1,431	1,393	38
Nursing, midwifery and health visiting learners	0	0	0	5	5	0
Scientific, therapeutic and technical staff	684	652	32	755	711	44
Social care staff	0	0	0	30	30	0
Agency and Contract staff	60	0	60	60	0	60
Bank Staff	153	0	153	153	0	153
Other	0	0	0	14	14	0
Total	**4,444**	**4,035**	**409**	**4,638**	**4,205**	**433**
Of which are engaged on capital projects	**3**	**3**	**0**	**3**	**3**	**0**

	Group			Trust		
	Year Ended 31 March 2014			Year Ended 31 March 2014		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	191	152	39	191	152	39
Administration and estates	910	847	63	910	847	63
Healthcare assistants and other support staff	930	897	33	930	897	33
Nursing, midwifery and health visiting staff	1,386	1,347	39	1,386	1,347	39
Nursing, midwifery and health visiting learners	17	17	0	17	17	0
Scientific, therapeutic and technical staff	688	645	43	688	645	43
Social care staff	61	61	0	61	61	0
Agency and Contract staff	46	0	46	46	0	46
Bank Staff	164	0	164	164	0	164
Other	1	1	0	1	1	0
Total	**4,394**	**3,967**	**427**	**4,394**	**3,967**	**427**
Of which are engaged on capital projects	**3**	**3**	**0**	**3**	**3**	**0**

Unit of measure is whole time equivalent (WTE).

7.3 Staff sickness absence

	Group & Trust	
	Year Ended 31 March 2015	Year Ended 31 March 2014
	Number	Number
Total days lost	45,352	46,154
Total staff years	4,235	4,207
Average working days lost	10.7	11.0

This information although based on Trust data is supplied for the accounts by the Department of Health.
The source for disclosure of this information is from the central electronic payroll records held at the Department of Health. The figures quoted are based on a reference period January to December, i.e. for 2014-15 January 2014 - December 2014.

7.4 Early retirements due to ill health

During the year there were 7 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health (8 during 2013/14). The estimated additional pension liabilities of these ill-health retirements is £670k (2013/14 £344k). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

7. Employee costs and numbers (continued)

7.5 Staff exit packages

30 redundancies were actioned by the Trust during the accounting period. The details of these are disclosed below.

The exit packages here were made either under nationally agreed arrangements or local arrangements approved by the Remuneration and Terms of Service Committee.

Group & Trust

31 March 2015

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages
	Number	£'000	Number	£'000	Number	£'000
Less than £10,001	5	16	20	70	**25**	**86**
£10,001 - £25,000	8	125	0	0	**8**	**125**
£25,001 - £50,000	6	226	0	0	**6**	**226**
£50,001 - £100,000	8	733	0	0	**8**	**733**
£100,001 - £150,000	4	493	0	0	**4**	**493**
£150,001 - £200,000	0	0	0	0	**0**	**0**
Total number of exit packages by type	**31**	**1,593**	**20**	**70**	**51**	**1,663**

The number of other departures agreed include 20 contractual payments made to individuals in lieu of notice.

Exit Packages: other (non-compulsory) departure payments	Payments agreed	Total value of agreements
	Number	£'000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	20	70
Exit payments following Employment Tribunals or court orders	0	0
Non-Contractual payments requiring HMT approval	0	0
Total	**20**	**70**
of which		
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0

8. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determines at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on the valuation data as at 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19 (Employee Benefits), relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

8. Pension costs (continued)

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

9. Operating leases

9.1 As lessee

The Group & Trust has three types of Operating Lease. These are for Photocopiers, Vehicles and Property.

Photocopiers are on an Crown Commercial Services (CCS) framework agreement with the contract negotiated on a five year lease term against the agreement for all print devices.

Vehicles are on a Purchasing and Supply Agency (PASA) NHS master lease agreement with typically three year terms.

Property is on commercial arms length contracts. At the end of the accounting period there were 44 lease properties, all with different Landlords. The rental periods range from 1 to 22 years. 8 leases relating to LIFT properties in Barnsley have been included from 2013/14. These expire at the higher end of the rental timeframe.

There are no contingent rents or sublease payments due or received.

	Group & Trust	
Operating lease payments	**Year Ended 31 March 2015 £000**	**Year Ended 31 March 2014 £000**
Minimum lease payments	7,026	7,103
	7,026	**7,103**

Future minimum lease payments due	**Year Ended 31 March 2015 £000**	**Year Ended 31 March 2014 £000**
Payable:		
Not later than one year	4,729	5,170
Between one and five years	11,289	11,768
After five years	22,904	25,408
Total	**38,922**	**42,346**

10. Finance Income	Group Year Ended 31 March 2015 £000	Group Year Ended 31 March 2014 £000	Trust Year Ended 31 March 2015 £000	Trust Year Ended 31 March 2014 £000
Interest on loans and receivables	95	88	95	88
NHS Charitable funds: investment income	2	5	0	0
Total	**97**	**93**	**95**	**88**

The Group & Trust has no interest on impaired financial assets included in finance income in 2014/15 or in 2013/14.

11. Finance Costs - interest expense

The Group & Trust incurred no finance costs in 2014/15 or in 2013/14.

12. Impairment of assets (PPE & intangibles)

	Group & Trust					
	31 March 2015			31 March 2014		
	Net Impairment £000	Impairments £000	Reversals £000	Net Impairment £000	Impairments £000	Reversals £000
Impairments charged to operating surplus / deficit:						
Other	**0**	0	0	**396**	396	0
Changes in market price	(290)	1,802	(2,092)	**2,437**	4,689	(2,252)
Total Impairments charged to operating surplus / deficit	**(290)**	**1,802**	**(2,092)**	**2,833**	**5,085**	**(2,252)**
Impairments charged to the revaluation reserve	0	0	0	3,518	3,518	0
Total Impairments	**(290)**	**1,802**	**(2,092)**	**6,351**	**8,603**	**(2,252)**

In 2014/15 the Trust undertook a desktop revaluation of the Estate, resulting in a net benefit of £290k.

Other impairments in 2013/14 relate to the IT assets transferred from NHS Barnsley on the 1st April 2013. These assets were individual items of IT equipment costing less than £5,000 which under the Trust Accounting Policy are not capitalised.

In 2013/14 the Trust undertook a full revaluation of the Estate. This led to increases in values on existing Trust estate which reversed previous impairments (principally on The majority of the impairment relates to NHS Barnsley Estate which transferred on the 1st April 2013 and was revalued using the same Modern Equivalent Asset (MEA) methodology as the existing Trust estate. This led to an impairment on these assets.

13 Intangible assets

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

13.2 Intangible assets 2013/14	Group & Trust	
	Total	Software licences (purchased)
	£000	£000
Gross cost at 1st April 2013	**871**	871
Transfers by absorption - Modified	**539**	539
Additions - purchased	**413**	413
Gross Cost at 31 March 2014	**1,823**	**1,823**
Amortisation at 1st April 2013	**414**	414
Transfers by absorption - Modified	**459**	459
Provided during the year	**177**	177
Amortisation at 31 March 2014	**1,050**	**1,050**
Net book value		
NBV - Purchased at 31 March 2014	**773**	773
NBV total at 31 March 2014	**773**	**773**

Transfers by absorption - Modified relate to Software licences transferred to the Trust from NHS Barnsley under the Estate Transfer on 1st April 2013. A summary of these transactions in shown under note 14.2.

13.3 Intangible assets

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

14.1 Property, plant and equipment 31 March 2015

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

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

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

14.2 Property, plant and equipment 31 March 2014

Group & Trust	Total	Land	Buildings excluding dwellings	Assets under Construction & Payments On Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2013	**79,024**	11,731	50,891	10,297	3,488	289	1,916	412
Transfers by absorption - Modified	**60,534**	7,686	48,633	0	1,045	546	1,957	667
Additions - purchased	**8,360**	270	4,677	2,337	410	26	248	392
Impairments charged to operating expenses (note 12)	**(396)**	0	0	0	0	0	(396) *	0
Impairments charged to the revaluation reserve (note 12)	**(3,518)**	(790)	(2,728)	0	0	0	0	0
Reversal of impairments credited to operating income	**0**	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	**0**	0	0	0	0	0	0	0
Reclassifications	**0**	0	10,175	(10,297)	122	0	0	0
Revaluations	**(31,447)**	(328)	(30,018)	0	0	0	(1,101) *	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2014	**112,557**	**18,569**	**81,630**	**2,337**	**5,065**	**861**	**2,624**	**1,471**
Accumulated depreciation at 1st April 2013	**10,691**	741	6,758	0	1,696	85	1,179	232
Transfers by absorption - Modified	**23,300**	0	20,605	0	829	360	1,382	124
Provided during the year	**4,968**	0	4,097	0	361	92	301	117
Impairments charged to operating expenses	**4,689**	250	4,439	0	0	0	0	0
Reversal of impairments credited to operating income (note 12)	**(2,252)**	(578)	(1,674)	0	0	0	0	0
Reclassifications	**0**	0	0	0	0	0	0	0
Revaluations	**(31,447)**	(328)	(30,018)	0	0	0	(1,101) *	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2014	**9,949**	**85**	**4,207**	**0**	**2,886**	**537**	**1,761**	**473**
Net book value								
Net book value at 31 March 2014								
NBV - Owned at 31 March 2014	**102,608**	18,484	77,423	2,337	2,179	324	863	998
NBV - Donated at 31 March 2014	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2014	**102,608**	**18,484**	**77,423**	**2,337**	**2,179**	**324**	**863**	**998**

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

On the 1st April 2013, Estate transferred from NHS Barnsley, a summary of this transaction is shown below (this is the net transaction):

	Property, Plant & Equipment	Total Assets			Total Liabilities
		Intangibles	Transferred	Capital Creditors	Transferred
	£'000	£'000	£'000	£'000	£'000
Transferred from NHS Barnsley	37,234	80	**37,314**	(1,573)	**(1,573)**

* The Property, Plant & Equipment transferred from NHS Barnsley,above, included Information Technology assets under £5,000 which did not meet the Trust accounting policy (note 1.7). As such these assets were transferred to the Trust as shown in the table above and have been subsequently revalued to zero leading to an impairment of £396k in 2013/14.

14.3 Economic Lives of Property, Plant and Equipment

	Group & Trust	
	Min Life Years	Max Life Years
Land	0	0
Buildings excluding dwellings	0	90
Dwellings	0	0
Assets under Construction & POA	0	0
Plant & Machinery	0	10
Transport Equipment	0	7
Information Technology	0	5
Furniture & Fittings	0	10

14.4 Finance Leases

The Group & Trust hold no finance lease assets.

15 Investments

15.1 Investments - Carrying Value

	Group & Trust	
	Property*	Property*
	31 March 2015	31 March 2014
	£000	£000
At Carrying Value		
Balance at Beginning of Period	410	410
Acquisitions/Reclassifications in year	0	0
Fair value gains (taken to I&E)	16	0
Fair value losses (impairment) (taken to I&E)	0	0
Transfers to/from assets held for sale and assets in disposal groups	0	0
Disposals	(86)	0
Balance at End of Period	**340**	**410**

* The Group & Trust has no other investments.

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

15.2 Investment Property expenses

The Group & Trust incurred £30k on investment property expenses in 2014/15 (£0k in 2013/14). These related to the potential sale of the properties.

15.3 Investments in subsidiaries

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

The following are summary statements before group eliminations which have been consolidated into these accounts in 2014/15.

Summary Statement of Financial Activities

	31 March 2015	31 March 2014
	£000	£000
Total Incoming Resources	67	314
Staff Costs	(31)	0
Resources expended with bodies outside the NHS	(309)	(373)
Net movement in funds	**(273)**	**(59)**

Summary Statement of Financial Position	31 March 2015	31 March 2014
	£000	£000
Cash and cash equivalents	542	541
Trade and other receivables	0	260
Trade and other payables	(23)	(9)
Net Assets	**519**	**792**
Other restricted income funds	0	29
Unrestricted income funds	519	763
Total Charitable Funds	**519**	**792**

Other restricted income funds relate to monies held by the Trust for Spectrum CIC (Community Interest Company), these were fully expended in 2014/15.

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

16.1 Non-current assets held for sale

The Group & Trust has no non-current assets held for sale in 2014/15 or in 2013/14.

16.2 Liabilities in disposal groups

The Group & Trust has no liabilities in disposal groups in 2014/15 or in 2013/14.

17. Other assets

The Group & Trust has no other assets in 2014/15 or in 2013/14.

18. Other Financial Assets

The Group & Trust has no other financial assets in 2014/15 or in 2013/14.

19. Inventories

19.1. Inventory Movements

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

	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2013	**560**	**58**	**502**
Additions	2,857	2,651	206
Inventories recognised in expenses	(3,135)	(2,649)	(486)
Carrying Value at 31 March 2014	**282**	**60**	**222**

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

20. Trade and other receivables

20.1 Trade and other receivables

	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
Current				
NHS Receivables	3,015	1,910	3,015	1,910
Receivables due from NHS charities – Revenue	0	0	22	3
Other receivables with related parties	1,031	2,124	1,031	2,124
Provision for impaired receivables	(107)	(277)	(107)	(277)
Prepayments	1,009	1,465	1,009	1,465
Accrued income	2,357	1,083	2,357	1,083
VAT receivable	167	155	167	155
Other receivables	484	307	484	308
NHS Charitable funds: Trade and other receivables	0	255	0	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**7,956**	**7,022**	**7,978**	**6,771**

The Group & Trust have no non current trade and other receivables as at 31 March 2015 (£0 (zero) as at 31 March 2014).

20.2 Provision for impairment of receivables

	Group & Trust 31 March 2015 £000	Group & Trust 31 March 2014 £000
Balance at start of period	277	127
Increase in provision	81	163
Amounts utilised	(67)	0
Unused amounts reversed	(184)	(13)
Balance at 31 March	**107**	**277**

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

20.3 Analysis of impaired receivables

	Group & Trust 31 March 2015 £000	Group & Trust 31 March 2014 £000
Ageing of impaired receivables		
0 - 30 days	5	80
30-60 Days	2	2
60-90 days	0	0
90- 180 days	13	13
over 180 days	87	182
Total	**107**	**277**

Ageing of non-impaired receivables past their due date	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
0 - 30 days	1,866	2,072	1,941	1,817
30-60 Days	60	649	60	649
60-90 days	82	90	82	90
90- 180 days	255	241	255	241
over 180 days	907	35	907	35
Total	**3,170**	**3,087**	**3,245**	**2,832**

20.4 Finance lease receivables

The Group & Trust has no finance lease receivables.

21. Cash and cash equivalents	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
Balance at 1st April	**33,655**	**30,710**	**33,114**	**29,855**
Net change in year	(496)	2,945	(497)	3,259
Balance at 31 March	**33,159**	**33,655**	**32,617**	**33,114**
Broken down into:				
Cash at commercial banks and in hand	632	663	90	122
Cash with the Government Banking Service	32,527	32,992	32,527	32,992
Cash and cash equivalents as in statement of financial position	**33,159**	**33,655**	**32,617**	**33,114**
Cash and cash equivalents as in statement of cash flows	**33,159**	**33,655**	**32,617**	**33,114**

Third party assets (Patient Monies) held by the Trust

	Group & Trust 31 March 2015 £000	Group & Trust 31 March 2014 £000
Bank balances	233	234
Monies on deposit	74	90
Total third party assets	**307**	**324**

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

22. Trade and other payables

22.1 Trade and other payables	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
Current				
NHS payables - capital	0	232	0	232
NHS payables - revenue	993	3,145	993	3,145
Amounts due to other related parties - revenue	2,787	2,877	2,787	2,877
Other trade payables - capital	770	2,566	770	2,566
Other trade payables - revenue	2,073	3,630	2,073	3,630
Social Security costs	1,879	1,811	1,879	1,811
Other taxes payable	1,522	1,539	1,522	1,539
Other payables	171	65	171	65
Accruals	10,336	7,322	10,336	7,322
PDC dividend payable	46	7	46	7
NHS Charitable funds: Trade and other payables	1	0	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**20,578**	**23,194**	**20,577**	**23,194**

The Group & Trust had no non current trade and other payables as at 31 March 2015 (£0 (zero) as at 31 March 2014).

22.2 Better Payment Practice Code

	Group & Trust	
Better Payment Practice Code - measure of compliance	**31 March 2015 Number**	**31 March 2015 £000**
Total Non-NHS trade invoices paid in the year	40,483	52,587
Total Non NHS trade invoices paid within target	37,390	46,060
Percentage of Non-NHS trade invoices paid within target	**92%**	**88%**
Total NHS trade invoices paid in the year	939	15,728
Total NHS trade invoices paid within target	810	13,899
Percentage of NHS trade invoices paid within target	**86%**	**88%**
	31 March 2014 Number	**31 March 2014 £000**
Total Non-NHS trade invoices paid in the year	43,406	48,993
Total Non NHS trade invoices paid within target	41,222	45,357
Percentage of Non-NHS trade invoices paid within target	**95%**	**93%**
Total NHS trade invoices paid in the year	891	11,351
Total NHS trade invoices paid within target	822	10,544
Percentage of NHS trade invoices paid within target	**92%**	**93%**

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

22.3 Early retirements detail included in NHS payables

The Group & Trust had no early retirement costs included in payables as at 31 March 2015 (£0 (zero) as at 31 March 2014).

22.4 Other liabilities

	Group & Trust	
	31 March 2015 £000	**31 March 2014 £000**
Current		
Deferred Income	751	843
TOTAL OTHER CURRENT LIABILITIES	**751**	**843**
Non-current		
Deferred Income	0	0
TOTAL OTHER NON CURRENT LIABILITIES	**0**	**0**

22.5 Other Financial Liabilities

The Group & Trust had no other financial liabilities as at 31 March 2015 (£0 (zero) as at 31 March 2014).

23. Borrowings

The Group & Trust had no borrowings as at 31 March 2015 (£0 (zero) as at 31 March 2014).

24. Provisions

	Group & Trust Current		Group & Trust Non-current	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000	£000	£000	£000
Pensions relating to other staff	58	56	589	584
Legal claims	93	77	916	770
Equal Pay	6	6	0	0
Redundancy	3,235	2,240	1,940	1,500
Other				
Injury Benefit	55	54	878	849
Other	334	1,074	0	0
Total	**3,781**	**3,507**	**4,323**	**3,703**

	Group & Trust					
	Total	Pensions relating to other staff	Legal claims	Equal Pay	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2014	7,210	640	847	6	3,740	1,977
Change in the discount rate	66	21	0	0	0	45
Arising during the year	6,428	44	269	0	5,934	181
Utilised during the year (accruals)	(29)	(15)	0	0	0	(14)
Utilised during the year (cash)	(2,648)	(43)	(107)	0	(1,593)	(905)
Reversed unused	(2,923)	0	0	0	(2,906)	(17)
At 31 March 2015	**8,104**	**647**	**1,009**	**6**	**5,175**	**1,267**
Expected timing of cash flows:						
Not later than one year;	3,781	58	93	6	3,235	389
Later than one year and not later than five years	3,293	223	916	0	1,940	214
Later than five years (see note 30.3).	1,030	366	0	0	0	664
Total	**8,104**	**647**	**1,009**	**6**	**5,175**	**1,267**

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

Redundancy - This provision, totalling £5.2m, relates to approximately 127 posts during 2015 / 2016 and a further 51 redundancies during 2016 / 2017. These are estimates based upon the Trust Annual Plan and Cost Improvement Programme.

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

Equal pay - this relates to provisions for 6 equal pay claims. The provision is for legal costs only. As per NHS guidance the Trust is not presently making a provision in terms of settlement of the claims.

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

Other - A £319k provision has been made in relation to a potential liability resulting from HMRC guidance on VAT recovery, this relates to a 4 year potential overclaim by the Trust.

£739K is included in the provisions of the NHS Litigation Authority at 31 March 2015 (£443k at 31 March 2014) in respect of clinical negligence liabilities of the NHS Trust.

25. Contingencies

25.1 Contingent liabilities

The Group & Trust had no contingent liabilities as at 31 March 2015 (none as at 31 March 2014).

25.2 Contingent assets

The Group & Trust had 1 contingent asset as at 31 March 2015 (1 as at 31 March 2014).

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

26. Revaluation reserve

	Group & Trust	
	Total Revaluation Reserve	**Revaluation Reserve - property, plant and equipment**
	£000	**£000**
As at 1 April 2014	**14,785**	**14,785**
Impairments	0	0
Revaluations	2,098	2,098
Transfers to other reserves	(102)	(102)
Revaluation reserve at 31 March 2015	**16,781**	**16,781**
	£000	**£000**
As at 1 April 2013	**7,261**	**7,261**
Transfers by absorption - Modified	11,042	11,042
Impairments	(3,518)	(3,518)
Other reserve movements	0	0
Revaluation reserve at 31 March 2014	**14,785**	**14,785**

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

27. Finance lease obligations

The Group & Trust had no finance lease obligations.

28. Finance lease commitments

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

29. Capital commitments

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

	Group & Trust	
	31 March 2015	**31 March 2014**
	£000	**£000**
Property, plant and equipment	4,831	1,925
Intangible assets	0	0
Total	**4,831**	**1,925**

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

30. Financial Instruments

30.1 Financial assets

	Group Total £000	Group Loans and receivables £000	Trust Total £000	Trust Loans and receivables £000
Assets as per SoFP				
Trade and other receivables excluding non financial assets (at 31 March 2015)	**7,956**	7,956	**7,978**	7,978
Cash and cash equivalents (at bank and in hand at 31 March 2015)	**32,617**	32,617	**32,617**	32,617
NHS Charitable funds: financial assets (at 31 March 2015)	**542**	542	**0**	0
Total at 31 March 2015	**41,115**	**41,115**	**40,595**	**40,595**
Trade and other receivables excluding non financial assets (at 31 March 2014)	**4,219**	4,219	**4,219**	4,219
Cash and cash equivalents (at bank and in hand at 31 March 2014)	**33,114**	33,114	**33,114**	33,114
NHS Charitable funds: financial assets (at 31 March 2014)	**796**	796	**0**	0
Total at 31 March 2014	**38,129**	**38,129**	**37,333**	**37,333**

30.2 Financial liabilities

	Group Total £000	Group Other financial liabilities £000	Trust Total £000	Trust Other financial liabilities £000
Liabilities as per SoFP				
Trade and other payables excluding non financial assets (31 March 2015)	**20,577**	20,577	**20,577**	20,577
Provisions under contract (at 31 March 2015)	**8,104**	8,104	**8,104**	8,104
NHS Charitable funds: financial liabilities (at 31 March 2015)	**1**	1	**0**	0
Total at 31 March 2015	**28,682**	**28,682**	**28,681**	**28,681**
Trade and other payables excluding non financial assets (31 March 2014)	**23,194**	23,194	**23,194**	23,194
Provisions under contract (at 31 March 2014)	**7,210**	7,210	**7,210**	7,210
NHS Charitable funds: financial liabilities (at 31 March 2014)	**0**	0	**0**	0
Total at 31 March 2014	**30,404**	**30,404**	**30,404**	**30,404**

30.3 Maturity of Financial liabilities

	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
In one year or less	24,359	26,601	24,358	26,601
In more than one year but not more than two years	2,968	972	2,968	972
In more than two years but not more than five years	325	1,816	325	1,816
In more than five years (see note 24)	1,030	1,015	1,030	1,015
Total	**28,682**	**30,404**	**28,681**	**30,404**

31. Financial risk management

Financial reporting standard IFRS 7 (Financial Instruments: Disclosures) requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has negligible exposure to currency rate fluctuations.

Interest rate risk
The Trust currently has no long term borrowing.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with clinical commissioning group's, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources; future capital expenditure will be funded in the same way or from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

32. Events after the reporting period
The Group & Trust has no events after the reporting period

33. Private Finance Initiative contracts
The Group & Trust has no Private Finance Initiative Contracts.

34. Related party transactions

During the year Board Members or members of the key management staff or parties related to them have undertaken material transactions with South West Yorkshire Partnership NHS Foundation Trust, these are noted below.

Steven Michael, Chief Executive. Member of Huddersfield University Business School Advisory Board, member of Leeds University Centre for Innovation in Health Management International Fellowship Scheme, member, Leeds University Centre for Innovation in Health Management, trustee Spectrum People, NHS Confederation elected Chief Executive representative, Mental Health Network Board, member of Health & Wellbeing Boards, Wakefield and Barnsley, Involvement in Care Quality Commission mental health inspection arrangements, and partner, NHS Interim Management and Support. Huddersfield University provided services to the Trust in 2014/15 to the value of £30,487 (2013/14 £97,268).

Ian Black, Chair of the Trust is a Non-Executive Director of Benenden Healthcare (mutual), Seedrs (with small shareholding), Chair, Family Fund, Chair, Keegan and Pennykidd (insurance brokers), Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and manager, Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire and has a private shareholding in Lloyds Banking Group PLC.

Alexandra Farrell, Deputy Chief Executive/Director of Finance: Spouse is General Practitioner partner, City View Practice, Leeds.

Helen Wollaston, Non Executive Director is a Director, Equal to the Occasion (consultancy) and WISE (Women in Science and Engineering).

Jonathan Jones, Non Executive Director is a Member, Squires Patton Boggs (UK) LLP and Squire Patton Boggs MENA LLP. Spouse is Company Secretary and a shareholder in Zenith Leasedrive Holdings Limited.

Laurence Campbell, Non Executive Director is Treasurer, Kirklees Citizen's Advice Bureau and Law Centre

Dawn Stephenson, Director of Corporate Development is a voluntary Trustee for Kirklees Active Leisure.

Sean Rayner, District Service Director, Barnsley and Wakefield is a member of the Independent Monitoring Board for HMP Wealstun and a Trustee of Barnsley Premier Leisure. Barnsley Premier Leisure provided services to the Trust in 2014/15 to the value of £232,421 (2013/14 £152,185).

Nette Carder, Interim District Director, CAMHS and forensic services, Director, Athena Leadership and Management Limited. Athena Leadership and Management provided services to the Trust in 2014/15 to the value of £36,433 (2013/14 £0 (zero)).

34.1 Related Party Transactions

	Group & Trust	
	Income	**Expenditure**
	£000	**£000**
Value of transactions with other related parties in 2014/15		
Department of Health	20	91
Other NHS Bodies	204,275	15,576
Other	0	0
Total	**204,295**	**15,667**

	Income	**Expenditure**
Value of transactions with other related parties in 2013/14	**£000**	**£000**
Department of Health	74	255
Other NHS Bodies	202,340	12,009
Other	25,302	4,573
Total	**227,716**	**16,837**

34.2 Related Party Balances

	Group & Trust	
	Receivables	**Payables**
	£000	**£000**
Value of transactions with other related parties in 2014/15		
Department of Health	0	46
Other NHS Bodies	4,170	2,467
Other	0	0
Total	**4,170**	**2,513**

	Receivables	**Payables**
Value of transactions with other related parties in 2013/14	**£000**	**£000**
Department of Health	6	73
Other NHS Bodies	2,268	3,959
Other	1,873	6,772
Total	**4,147**	**10,804**

35. Losses and Special Payments

	Group & Trust			
	Year Ended 31 March 2015 Total number of cases Numbers	Year Ended 31 March 2015 Total value of cases £000s	Year Ended 31 March 2014 Total number of cases Numbers	Year Ended 31 March 2014 Total value of cases £000s
Losses:				
1. Losses of cash due to:				
a. theft, fraud etc	0	0	2	0
b. overpayment of salaries etc	0	0	0	0
c. other causes	1	0	1	(1)
2. Fruitless payments and constructive losses	0	0	0	0
3. Bad debts and claims abandoned	0	0	0	0
4. Damages to buildings, property etc. (including stores losses)	0	0	0	0
Total Losses	**1**	**0**	**3**	**(1)**
Special Payments				
5. Compensation under legal obligation	0	0	0	0
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments				
a. loss of personal effects	36	4	28	3
d. other negligence and injury	0	0	5	0
8. Special severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	3	3
Total Special Payments	**36**	**4**	**36**	**6**
Total Losses and Special Payments	**37**	**4**	**39**	**5**

All amounts are reported on an accruals basis but exclude provisions for future losses.

There were no clinical negligence cases where the net payment exceeded £300,000.

There were no fraud cases where the net payment exceeded £300,000.

There were no personal injury cases where the net payment exceeded £300,000.

There were no compensation under legal obligations cases where the net payment exceeded £300,000.

There were no fruitless payments where the net payment exceeded £300,000.

36. Going Concern

After making enquiries, the directors have a reasonable expectation that the Group & Trust have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

37 Salary and Pension entitlements of senior managers

37.1 Remuneration

The Salary and Pension entitlements of senior managers are set by the 'Remuneration and Terms of Services Committee' which is a sub-committee of the Trust Board. The members of this committee in 2014/15 were: Ian Black (Chair of the Committee, Chair of the Trust), Jonathan Jones (Non-Executive Director of the Trust), Helen Wollaston (Non-Executive Director of the Trust), Steven Michael (Chief Executive) with Alan Davis (Director of Human Resources & Workforce Development) in attendance and Bernie Cherriman-Sykes who is committee secretary.
The Trust follows national guidance on pay and terms and conditions for Senior Managers and the contracts are substantive contracts with NHS termination arrangements.

Name and Title	31/03/2015						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Ian Black, Chair	40 - 45	4.0			2.9		50 - 55
Bernard Fee, Non-Executive Director (Left 26/05/14)	0 - 5				0.6		0 - 5
Peter Aspinall, Non-Executive Director	15 - 20				1.2		15 - 20
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director	15 - 20						15 - 20
Julie Fox, Non-Executive Director	10 - 15				1.3		10 - 15
Laurence Campbell, Non-Executive Director (Joined 01/06/14)	10 - 15				0.5		10 - 15
Steven Peter Michael, Chief Executive	170 - 175	2.0			0.6	17.5 - 20.0	190 - 195
Nisreen Hanna Booya, Medical Director (Left 30/09/14)	15 - 20			55 - 60			70 - 75
Alan George Davis, Director of Human Resources and Workforce Development	110 - 115	2.8				97.5 - 100.0 *	215 - 220
Alexandra Farrell, Deputy Chief Executive/Director of Finance	120 - 125		0 - 5			47.5 - 50.0 *	175 - 180
Dawn Stephenson, Director of Corporate Development	85 - 90	5.3	0 - 5		0.2	(55.0 - 57.5) *	40 - 45
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	105 - 110	1.1	0 - 5		0.2	80.0 - 82.5 *	195 - 200
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	30 - 35	5.7		110 - 115	2.2	140.0 - 142.5 *	285 - 290
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		0 - 5		1.1	(5.0 - 7.5)	100 - 105
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100		0 - 5		1.4	(5.0 - 7.5)	95 - 100
Nette Carder, Interim District Director, CAMHS and forensic services (from 05/01/15)	35 - 40						35 - 40
Diane Smith, Interim Director of Service Innovation and Health Intelligence (secondment from NHS England to 31/12/14)	85 - 90						85 - 90
Diane Smith, Director of Service Innovation and Health Intelligence (Substantive from 01/01/15)	20 - 25					(27.5 - 30.0)	(5 - 10)

Name and Title	31/03/2014						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Ian Black, Chair	45 - 50				2.6		45 - 50
Bernard Fee, Non-Executive Director	10 - 15				0.8		10 - 15
Peter Aspinall, Non-Executive Director	15 - 20				1.1		15 - 20
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director	15 - 20				0.2		15 - 20
Julie Fox, Non-Executive Director	10 - 15				1.7		10 - 15
Steven Peter Michael, Chief Executive	165 - 170	2.8	5 - 10		0.2	72.5 - 75.0	245 - 250
Nisreen Hanna Booya, Medical Director	30 - 35			80 - 85			110 - 115
Alan George Davis, Director of Human Resources and Workforce Development	95 - 100	2.9	0 - 5		0.2	15.0 - 17.5	120 - 125
Alexandra Farrell, Deputy Chief Executive/Director of Finance	110 - 115		0 - 5		2.3	12.5 - 15.0	135 - 140
Dawn Stephenson, Director of Corporate Development	90 - 95		0 - 5		0.7	(267.5 - 270.0)	(165 - 170)
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	95 - 100	0.8	0 - 5		0.4	35.0 - 37.5	135 - 140
Anne Basford, District Service Director, Calderdale and Kirklees (Left 04/07/13)	25 - 30	1.1	0 - 5		0.3	12.5 - 15.0	45 - 50
Adrian Berry, Director of Forensic Services	25 - 30	9.1		100 - 105		0 - 2.5	135 - 140
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		0 - 5			7.5 - 10.0	110 - 115
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100	0.5	0 - 5		1.1	(27.5 - 30.0)	70 - 75
Diane Smith, Interim Director of Service Innovation and Health Intelligence (Joined 09/01/14) (Secondment from NHS England)	10 - 15						10 - 15

	31/03/2015	31/03/2014
Band of Highest Paid Director's Total Remuneration (£000's)	170 - 175	190 - 195
Median Total Remuneration* £'s	27,306	27,463
Remuneration Ratio	6.4	7.0

The Remuneration Ratio is a comparison of the highest paid director and the median remuneration of all staff. The Median Total Remuneration and the Remuneration Ratio do not include the value of Pension Related Benefits in their calculation.

* There are a number of large increases in the pension related benefits field. The main reasons for these changes are noted below.

Alan George Davis, Director of Human Resources and Workforce Development	Impact of salary change from 2013 / 2014 to 2014 / 2015
Alexandra Farrell, Deputy Chief Executive/Director of Finance	Impact of salary change from 2013 / 2014 to 2014 / 2015
Dawn Stephenson, Director of Corporate Development	Impact of salary change from 2013 / 2014 to 2014 / 2015
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	Impact of salary change from 2013 / 2014 to 2014 / 2015
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	Impact of new role secured during 2014 / 2015

The Trust operated a Performance Related Pay scheme (PRP) for Directors. The scheme in 2014/15, which is non attributable and non pensionable and has a maximum value of 10%, provides for a maximum award of 5% for achieving all three Gateway Objectives and discretion for the Remuneration and Terms of Service Committee to award 2% where 2 out of the 3 are achieved. If one or no gateway objectives are achieved no performance awards are made. PRP above that awarded for achievement of gateway targets is recommended by the Chief Executive, based on the appraisal of the individual Director performance and approved by the Remuneration and Terms of Service Commitee to a maximum of 5%. In 2013/14 the award was a one off bonus, which is non attributable and non pensionable and has a maximum value of 6%. Eligibility for PRP requires the Trust to achieve 3 gateway objectives which entitle the Director to 1.5% performance award. PRP above 1.5% is recommended by the Chief Executive, based on the appraisal of individual Director performance and approved by the Remuneration and Terms of Service Committee.

For 2014/15 the accounts include £100k accrual as an estimate for the award of PRP which related to 2014/15 performance. The PRP award will be proposed by the Chief Executive and will be approved by the Remuneration and Terms of Service Committee in 2015/16. This will be disclosed in detail in the remuneration report in the 2015/16 accounts.

The Annual Performance Related pay in 2014 / 2015, disclosed in the table above, relates to payments made in 2014 / 2015 for performance in 2013 / 2014 which was approved by the Remuneration and terms of service Committee in 2014 / 2015.

Other remuneration for 2014/15 relates to payment for substantive clinical posts held within the Trust.

Expenses for 2014/15 are predominately the reimbursement of travel expenses.
The benefits in kind relate to child care vouchers, relocation expenses, cycle to work scheme, staff lease cars, NHS Phone Scheme or expenses paid in accordance with the Trust's Removal Expenses Policy (which includes provision of accommodation).

2013/14 Pension related benefits have been restated following updated guidance from Monitor which clarified the Pension related benefits calculation. A summary of this movement is shown in the table below.

	Restated 13/14	Original 13/14	Movement
Steven Peter Michael, Chief Executive	72.5 - 75.0	15 - 20	55.0 - 57.5
Alan George Davis, Director of Human Resources and Workforce Development	15.0 - 17.5	5 - 10	10.0 - 12.5
Alexandra Farrell, Deputy Chief Executive/Director of Finance	12.5 - 15.0	5 - 10	7.5 - 10.0
Dawn Stephenson, Director of Corporate Development	(265.0 - 267.5)	(40 - 45)	
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	35.0 - 37.5	5 - 10	32.5 - 35.0
Anne Basford, District Service Director, Calderdale and Kirklees (Left 04/07/13)	12.5 - 15.0		12.5 - 15.0
Adrian Berry, Director of Forensic Services	0 - 2.5		0 - 2.5
Sean Rayner, District Service Director, Barnsley and Wakefield	7.5 - 10.0	0 - 5	2.5 - 5.0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	(27.5 - 30.0)	(0 - 5)	(25.0 - 27.5)

* The median remuneration is the total remuneration of Trust staff member(s) lying in the middle of the linear distribution of the total staff, excluding the highest paid director. This is based on annualised, full-time equivalent remuneration as at the reporting period date.

.....Steven Michael, Chief Executive 22.5.15 .....Date

37.2 Pension Benefits

Name and title	Normal retirement age	Real increase/ (decrease) in pension and related lump sum at retirement age (bands of £5000) £000	Total accrued pension and related lump sum at retirement age at 31 March 2014 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase (Decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension Rounded to 1 decimal place £000
Steven Peter Michael, Chief Executive	60	7 - 10	255 - 260	1,223	1,124	68	0
Alan George Davis, Director of Human Resources and Workforce Development	60	20 - 25	190 - 195	987	831	133	0
Nisreen Hanna Booya, Medical Director (Left 30/09/14)*		-	-			-	0
Alexandra Farrell, Deputy Chief Executive/Director of Finance	60	10 - 15	140 - 145	689	597	76	0
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	65	5 - 10	85 - 90	506	413	81	0
Adrian Berry, Director of Forensic Services (to 30/09/14), Medical Director (from 01/10/14)	55	25 - 30	225 - 230	1,060	824	131	0
Dawn Stephenson, Director of Corporate Development	60	(5 - 10)	145 - 150	745	739	(13)	0
Sean Rayner, District Service Director, Barnsley and Wakefield	60	0 - 5	145 - 150	681	639	25	0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	55	0 - 5	165 - 170	786	738	28	0
Diane Smith, Director of Service Innovation and Health Intelligence (Substantive from 01/01/15)	60	(0 - 5)	135 - 140	721	785	(21)	0

* Nisreen Booya was in receipt of pension from 30/09/11 and so the pension, related lump sum and CETV is nil.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

.....Steven Michael, Chief Executive.....22-5-15.....Date