With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual Report and Accounts

for the period 1 April 2015 to 31 March 2016

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE PERIOD 1 APRIL 2015 TO 31 MARCH 2016

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

Message from the Chair

Welcome to the Trust's annual report for the year 1 April 2015 to 31 March 2016.

This has been a year of increasing challenge and considerable change for the NHS as a whole and also for our Trust. There are increasing demands across all our services as well as significant financial and workforce pressures; however, as a Trust we are in a good position to weather these challenges and to be resilient maintaining our focus on the quality and continuous improvement of the services we deliver. Throughout the year, as an organisation, we can all be proud that we have maintained our values at the forefront of what we do. I hope our reputation amongst the people who use our services, our staff and our stakeholders and partners is testament to this.

Our staff and the work they do are our most important assets and, in a climate where the NHS comes in for much criticism, 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 and carers. For this I thank all our staff. I find it particularly heartening when they are recognised for the work they do. The following is just a selection of what our staff have achieved.

- Our forensic child and adolescent mental health service won the outstanding 'Collaborative Leadership of the Year' award, regional NHS Leadership Academy awards and a team member won Mental Health Social Worker of the Year and Overall Social Worker of the Year 2015.
- The Trust as a whole was listed in Health Service Journal Best Places to work
- Our Barnsley end-of-life care team were shortlisted on the 'Multidisciplinary Teamwork' award category at the 2015 International Journal of Palliative Nursing awards.
- We were finalists in Health Service Journal 'Board of the Year' as well as at the Regional Leadership Recognition Awards.
- Our memory assessment tool was shortlisted at the 2015 Advancing Healthcare awards.

I also want to congratulate Paula Phillips, Service Manager/Nurse Consultant in Forensic Child and Adolescent Mental Health Services (CAMHS), who was honoured in the New Year's Honours with a MBE. The Trust's previous Medical Director, Nisreen Booya, was also honoured with a MBE for services to healthcare, particularly mental health.

The primary reason for our Trust in achieving a financial surplus is to invest in improving and developing our services. In 2015/16, we have done this through our transformation programme and through safer staffing. Our capital programme has also seen considerable investment in the creation of community hubs with Laura Mitchell Health and Wellbeing Centre opening in Halifax and the refurbishment of premises in New Street, Barnsley, completed. Work has also begun on community hubs in Pontefract and Wakefield, which will come on stream next year. The Board also approved a £16.1 million investment in non-secure in-patient services on the Wakefield site, which began in 2015/16.

We are open, honest and transparent as an organisation and welcome external challenge. The Care Quality Commission did a full inspection of the trust in March 2016 and, at the time of writing, we are awaiting our final report. Part of their immediate feedback was that they found our staff to be, without exception, caring. It is something that we have always been confident of but it gives us immense pride to have it confirmed by fresh eyes.

When we receive our CQC report, it should accelerate the improvements we are in the process of making and bring new insights into areas that we need to focus on. This will help shape our quality improvements for the coming year. We know that there is a lot to do – our annual report and Quality Accounts show how we are getting better and the areas where we must keep pushing. As a self-determining, confident organisation, we will continue doing what is right for our staff, our patients and the people we serve. We will only succeed by working together and with our partners.

In June 2015, we commissioned our auditor, Deloitte, to undertake a review of our governance arrangements under the well-led framework for foundation trusts. Our Board was pleased with the outcome, particularly as it was consistent with the Board's own self-assessment. There are a number of areas for development, which we see as an opportunity for improving what we already do.

I also want to take this opportunity to thank all of our governors for the work they do and the excellent contribution they make and support they provide becoming more and more involved in the governance and accountability of the Trust.

This year has seen much change at Board-level with three new non-executive directors joining us to replace two long-standing and experienced people. That this change has been effected with little impact on the stability of our Board is testament to our strength and constancy.

Lastly, I would like to thank Steven Michael, both on behalf of all at the Trust and personally, for his leadership of the Trust over the last nine years. That the Trust has such a strong platform to work from, built on a track record of achievement and putting service users at the heart of everything we do is in large part due to Steven and his leadership. Recognition of his achievements nationally supports this and I wish him every success in his retirement. Steven has built an excellent foundation for our new Chief Executive, Rob Webster, to build on in the coming years.

Looking ahead, we face significant challenges. 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; I hope you find it interesting and informative.

Ian Black
Chair
23 May 2016

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SECTION 1 – PERFORMANCE REPORT

Section 1.1 Overview

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 medium and low secure 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 a 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 to deliver high quality services for local people. Working in partnership also means working with our members, who have a say in how we run the Trust and how they wish our services to be developed. Around 15,500 local people (including our staff) are currently members.

The Trust now employs around 4,600 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. In a typical month we make more than 40,000 mental health and learning disability contacts and 45,000 community health service contacts

Our mission, values and strategic goals

Our mission is to enable people to reach their potential and live well in their community. To do this, we will:

- focus on recovery and self-care, working in partnership through, for example, our recovery colleges, Creative Minds and Altogether Better programmes;
- deliver service transformation and efficiency, reviewing our service offers to ensure we offer high quality, consistency and efficiency;
- make sure our support services are efficient and effective, for example, by ensuring we make best use of technology and invest in our estate; and
- work in partnership, offering integrated services based around local communities.

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.**

Our strategic approach is built on our values and on the partnerships we foster and develop with the people who use our services, 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 low and medium secure (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.

Review of 2015/16 – our highlights

This has been another challenging yet successful year for the Trust. Against a national backdrop of challenge and change, we have continued to work towards and achieve our objectives, putting our values at the heart of everything we do. This is reflected in an improving picture on quality performance, the achievement of a financial surplus and the attainment of a governance risk rating of 4 from Monitor.

This year has seen changes throughout our organisation, including, for our Board, three new non-executive directors to replace two long-standing and experienced individuals. The strength and stability of our Board means we have been able to effect the transition successfully and effectively. This year also saw the retirement of our Chief Executive, Steven Michael, on 31 March 2016 and the appointment of a successor, Rob Webster (from 16 May 2016). Through robust interim arrangements, we have managed the transition period effectively and efficiently.

Early in March 2016, our services were inspected by the Care Quality Commission (CQC). We are awaiting our report from the CQC; however, part of their immediate feedback was that they found our staff to be, without exception, caring. It is something of which we are proud and that we have always been confident of but it gives us immense pride to have it confirmed independently. The CQC also stressed how impressed they were that we were responding to an extremely challenging environment while maintaining positive morale and recognised the strength of our partnership working.

In June 2015, we commissioned Deloitte to undertake a review of our governance arrangements under the well-led framework for foundation trusts. There were no ‘material governance concerns’ arising from the review and, out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. There were a number of development areas identified during the review, which our Board is taking forward.

Throughout 2015/16, we achieved the targets set for us by Monitor, our Regulator. During the last quarter, we saw a small under-achievement in two areas relating to early intervention, which has not impacted on the clinical quality of the services we provide, and improving access to psychological therapies, where we have experienced difficulties in recruiting suitably trained staff to the service.

We also achieved the financial targets set by our Board, achieving an improved end-of-year financial position and enabling us to invest in a £16.1 million programme to improve in our non-secure services on our Fieldhead site. We have achieved both our governance and financial risk ratings set by Monitor achieving green and 4 (the highest) throughout the year.

Working in partnership is central to what we do. We are involved in local Vanguard initiatives, in the development of Sustainability and Transformation Plans in both South and West Yorkshire, and in the development of an accountable care organisation in Barnsley. Our partnership with Locala continues to provide community services in Kirklees and we deliver liaison services in partnership with both local acute trusts. Earlier this year, a bid with Leeds Community Healthcare NHS Trust for integrated healthcare services at Wetherby Young Offenders Institute and Adel Beck Secure Children's Home was successful. The Trust delivers child and adolescent mental health services (CAMHS) within this service.

Two areas of service have been particularly challenging in 2015/16. For our CAMHS, targeted improvement work in Calderdale and Kirklees, through a summit process, and in Barnsley, through a continuous service improvement plan, has resulted in significant progress in reducing waiting times and improving access. This progress will be maintained as we enter 2016/17.

In March 2016, our board took a very difficult decision to withdraw from the provision of Barnsley's 0-19 healthy child programme, commissioned by Barnsley Council. This followed several months of collaborative working to find a way to deliver a safe service, which also meets the vision for a new services model and the need to reduce costs. Unfortunately, we were unable to reach an agreement on how the model could be delivered within the resources available. The contract officially ended on 31 March 2016 for health visiting and on 31 May 2016 for school nursing. We will continue to provide the service for six months to ensure a safe transfer of the service and to allow time for the transfer of staff.

Key risks

In our plan for 2015/16, we identified a number of risks to quality, and operational delivery and operational resilience and set out how we would address these during the year.

We identified
CAMHS quality and access
We acted
We have improved access to our CAMHS. Additional funding for urgent care and significant investment of resources by the Trust in Calderdale and Kirklees has resulted in significant progress to reduce waiting times and improve access. Although this progress will be maintained as we enter 2016/17, uncertainty in relation to additional resources from commissioners and the plan to tender the services in both districts present a continued risk to the Trust.

We identified
Imbalance of demand and capacity for mental health beds leading to an increase in out-of-area treatment and a reduction in quality and efficiency.

We acted
We have reduced the number of out-of-area treatments. We will continue the work to transform both mental health acute and community pathways to ensure more effective working and easier access to intensive home-based treatment, focusing on a plan for every individual who uses our services.

We identified
Failure to meet quality key performance indicators in community mental health services, such as routine referral access times and cluster reviews.
We acted
We have improved performance through better engagement with our staff. Performance remains a challenge and we have clearly communicated the rationale for our quality indicators ensuring these are understood, there is team ownership of data and clear roles and responsibilities.

We identified
Failure to move transformation projects into benefits realisation requiring substitute cost savings impacting negatively on operational quality and delivery.
We acted
This will continue to be a risk and a priority for the next years. We are building on progress that has been monitored closely by Transformation Programme Boards and cost savings by the Executive Management Team and the Operational Requirement Group. There have been concerns in relation to the pace of transformation and the skills needed in clinical areas to support and engender change, good progress has been made, particularly in services for people with learning disabilities. We commissioned a productivity project from Meridian in inpatient and community older adult teams to support our transformation which has brought clarity and focus. The quality impact assessment process has been used to ensure any impact of cost savings on the quality of our services is managed.

We identified
Income and skills lost through contract tendering processes, which erodes capability, operating efficiency and sustainability.
We acted
We have developed a revised, proactive approach to marketing and relationship management, put in place more effective bid management processes and provided enhanced training for staff, and, through further development of service line reporting, better understand the risks of tendering for opportunities.

We identified
Inability to find operating models that fit commissioners' assumptions resulting in an erosion of market share and sustainability.
We acted
We have begun to develop a proactive approach to marketing and relationship management to understand and help shape expectations. Clinical leads contribute to innovation and thought leadership in developing optimal models and pathways of services.

We identified
The pressure and pace of change erodes staff engagement leading to a reduction in delivery and quality.
We acted
Through a revised staff engagement strategy and development of a revised approach to communication and engagement with staff, improvements have been made to how we communicate with and involve staff, particularly in the transformation of our services. The introduction of leadership and management arrangements based on a 'trios' where a clinical lead, general manager and practice governance coach work together and carry responsibility

at ward, unit and department level, is enacting the service change required to achieve transformation. Around 2,000 staff were involved in our local wellbeing survey, which helped to inform the revised engagement strategy.

We identified
Austerity impacting on partners will undermine integrated pathways threatening quality and efficiency.
We acted
Through an ongoing analysis of risk in integrated pathways and within integrated team, clarity with partners and staff on roles and responsibilities and communication with stakeholders, the Trust has managed the impact of on its local authority partners during 2015/16. Where we have seen changes to local authority commissioning, for example, on the delivery of children's services in Barnsley, we have worked closely with local government to ensure services are provided by the most appropriate provider in the most appropriate way. This has included making decisions about not being a provider of some services.

The Trust also experienced two issues during 2015/16 relating to information management and technology. Firstly, the Trust reported a serious incident in December 2015 in relation to the upgrade of its mental health clinical information system, RiO. This was as a result of significant technical and operational issues resulting from the upgrade. The incident was investigated through the standard investigation procedure and the Trust commissioned an independent review by Deloitte. This will report to the Board-level Information Management and Technology Forum in June 2016 and then Trust Board on 28 June 2016. Although system performance has improved, this has not been to a level necessary for full operational capacity; therefore, the operation of the clinical information system remains a significant clinical, technical and operational risk for the Trust.

Secondly, in August 2015, the Trust reported an incident to the Information Commissioner's Office (under new reporting requirements). This related to a serious IT virus affecting the Trust's network, resulting in the shutdown of the Trust's systems across all locations. The Trust worked with its IT service provider, Phoenix, and McAfee (virus protection provider) to rectify the problem and business continuity plans were implemented. Although staff were unable to use electronic systems, there was no reported impact on the service the Trust provides to its service users/patients. The Trust instigated an investigation into the incident and its own response and a number of areas from which the Trust can learn have been identified.

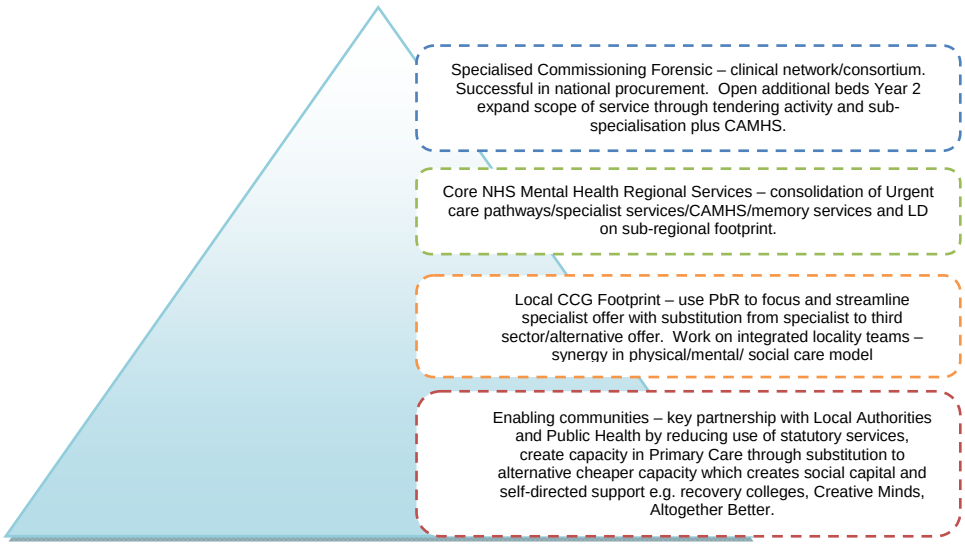
Going concern

The Trust prepares an annual plan each year, which is approved by Trust Board and submitted to Monitor for review. For 2016/17, the detailed operational plan covers 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.

Section 1.2 Performance analysis

Our Board identified a four-step model (below) to support the Trust through the next challenging phase. This articulates how the Trust's business model will support its sustainability by driving and re-shaping its cost base. We will do this through efficiencies in workforce, service models and infrastructure. This will be augmented by 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. Although there have been changes in the external environment, our Board remains of the view that, from 2016/17 onwards, 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.



To support this approach, a number of key areas for delivery were identified in our plan for 2015/16.

Strategic goal	2015/16 summary
Focus on recovery and self-care	• Recovery colleges in all four of our districts continue to deliver and develop alternative capacity for people who use our services and others, underpinned by the principles and values of co-production. Our recovery colleges are examples of recovery in action. A plan is also in place to develop a recovery college in forensic services with initial sessions delivered on 'What is Recovery? • Creative Minds continues to grow and develop, delivering creative projects in partnership with over 50 community organisations. In 2015, Creative Minds won a national award (Patient Experience Network National Awards (PENNA)) for 'strengthening the foundation' category and was runner up in two other categories. Its brand recognition continues to grow. Creative Minds was also recognised by NESTA as a pioneer in co-production and is now supported to spread learning nationally. • We have strengthened our operational links with primary care, the third sector and local authorities to support resilient communities. For example, in North Kirklees, our older people's mental health team's work with local GPs has been nominated

Strategic goal	2015/16 summary
	for an award in recognition of work to streamline pathways for people with cognitive impairment and their carers. • As part of the transformation of our mental health services, we have begun to develop innovative service models for integrated 'whole person' physical and mental health with primary care. A 'physical health checks in mental health' pilot project commenced earlier this year, which will enhance physical health screening, intervention and engagement with primary care.
Deliver transformation and cost savings	• Our transformation schemes continue to progress. • For learning disability services, new models of care have been tested and agreed with partners, including people who use our services and staff who work within them. The change to our bed-base, which sees the amalgamation of two sites into one specialist unit, is underway. Our services are aligned with local Transforming Care Plans and with the national drive to help more people to leave institutional settings and live independently. • For older people's services, new integrated models of dementia diagnosis and support are being put in place through, for example, Care Closer to Home integration in Kirklees and a pilot in Barnsley. There is also agreement with partners to proceed to design future service models. • The pathway for acute and community mental health services has been designed and agreed following extensive consultation with people who use our services, staff and our stakeholders. The project has now moved to the implementation phase and consultation with staff has begun. • We have invested heavily in Tier 3 child and adolescent mental health services in Calderdale and Kirklees through both financial and other resources, and this has been successful in engaging commissioners and other stakeholders. • The West Yorkshire Urgent and Emergency Care Vanguard is progressing work to improve the mental health urgent care pathway across West Yorkshire and this learning is reflected in both the South and West Yorkshire Sustainability and Transformation Plans. • Work has begun to drive 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 phase of transformational change in both service provision and support services. This will be used to drive the Trust's cost improvement programme in 2016/17 and beyond. • We achieved a savings target of £8.3 million during the year, which represents a shortfall in delivery of £1.4 million in-year (target £9.7 million). This position was achieved with £5.7 million (59%) delivered as set out in the original programme and £2.6 million (27%) through mitigation and substitution.
Effective and efficient support services	• In support of quality and transformation, we have invested in our estate to ensure we continue to deliver effective and efficient services in the communities we serve. During 2015/16, we completed development of two new community hubs for Calderdale with a new development in Halifax, and for Barnsley with the re-development of an existing site in New Street. The Laura Mitchell Health and Wellbeing Centre won an award for its innovative and welcoming design built on an existing site with central access. • Work on two further hubs has commenced and is expected to

Strategic goal	2015/16 summary
	complete in 2016/17 in Wakefield and Pontefract. Next year will also see the commencement of significant capital investment in non-secure in-patient facilities on our Fieldhead site. • In 2015/16, we continued to invest in the development of our information management and technology infrastructure and clinical and corporate systems to support our staff and people who use our services, delivering key systems that are fit for purpose and user-friendly. We have continued to roll-out technology to enable more of our staff to work in an agile way, spending more time with service users and less time in team base locations. This style of working is supported by our investment in our community hubs. • We continue to develop and implement initiatives such as appointment reminders by text to make access to our services easier. • To embed the principles of systems leadership, engage in a dialogue of transformational change with leaders within the Trust, and benchmark using good practice, we designed and delivered our Middleground 4 programme to more than 500 managers. • We also designed and implemented a 'Journey Story' framework to identify innovative practice, share learning and review the impact of systems-working. • During the year, we established and facilitated dedicated networks to foster engagement, support innovation, share learning and allow peer support and challenge, including a Practice Governance Coach Network and a Ward Managers' Network. • Our Board also approved a Staff Engagement Strategy, which has been implemented during the year.
Partnership and income generation	• During the year, we have continued to develop proactive commercial marketing and relationship management in line with the Dalton Review. This is supported by investment to develop and introduce a customer relationship management approach to our stakeholders and partners. • We are involved in many local partnership initiatives, such as Vanguards and other similar place-based integration initiatives, and the implementation of Care Closer to Home in Kirklees continues. • 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.

Service developments

Our transformation programme is one of the ways in which we are ensuring our services are 'fit for today and ready for tomorrow' reflecting our values and mission to move towards a broader, system-wide enabling role for many services.

The aim of our **acute and community (mental health)** workstream is to support our vision to provide services that are safe and person-centred, encourage greater control for individuals, and emphasise recovery and positive outcomes. Our work is re-designing services to deliver care to people who use our services in a more effective and efficient way to improve quality at reduced cost, increase links to alternative community-based services, promoting partnership working, optimise the use of technology, and use evidence-based best practice. Strong progress has been made over recent months with the development of

a revised model of service following engagement and consultation with people who use our services and our staff, and the workforce required to deliver.

The aim of our **rehabilitation and recovery** workstream is to ensure our services support people needing longer-term rehabilitation as part of their recovery to live in their own community as far as possible. Where specialist in-patient facilities are required these will be clearly focused on recovery and as close to home as possible. We have an agreed community model, which establishes an intensive community rehab support service to deliver intensive rehabilitation support for people in their own communities, integrated within existing community teams in an enhanced pathway. Work continues with our commissioners to ensure people can be supported in the community and to determine an appropriate model for in-patient facilities.

For **older people's mental health**, progress has been made to move to the design stage, which will focus on options for the future provision of services. Community engagement events have been held and workshops with staff and commissioners. A review has improved productivity of care co-ordinators within community teams with aspirations to increase further.

Work to revise our services for people with learning disabilities is well advanced with good progress made during 2015/16 to meet our vision to provide timely and effective specialist health services for people with learning disabilities who need extra help to live safely and well. We are on target to introduce new models of service supported by revised staffing models in the early part of 2016/17. Work to develop our new model of service has been based on extensive public stakeholder engagement and the amalgamation of in-patient services on the Horizon Centre at Fieldhead, Wakefield, has been achieved.

Good progress has been made under the **general community services** workstream. For therapy services, we have completed the move of musculo-skeletal, podiatry and administration services to our community hub at New Street, Barnsley. For community nursing, a testing phase has been completed to provide community-based working in defined localities which align with primary and social care has been undertaken with community matrons, the heart failure services, Parkinson's disease service and care navigation. Work will continue in the coming year. A review of administrative support arrangements is underway to establish an integrated support hub and a single point of access for approach for therapy and community nursing services.

The Trust's plan for 2015/16 set out a deficit financial position of £0.7 million. This provided 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 provided a recurrent surplus of £3.5 million and maintained an overall continuity of service risk rating of 4.

During the year, our Board reviewed and assessed its financial position at the request of its Regulator, Monitor, and agreed a revised plan to provide a £100,000 surplus. A year-end position of £207,000 surplus has been possible through the use of Trust reserves to offset in-year pressures arising from healthcare contract income and non-pay expenditure within our services.

Mental health museum

Back in 2011, the Trust's Change Lab initiative identified that the museum on our Fieldhead site had great potential. The working group, consisting of services users and carers and

supported by Trust staff, identified that the museum could be used to break down barriers, reduce stigma and discrimination in our society. Since then, with professional museum support and ongoing collaboration with service users, carers, staff and the community, the museum has developed into the Mental Health Museum. It is a unique museum and houses a remarkable collection of mental health-related objects that span the history of mental health care from the early 19th century through to the present day. In September 2015, the museum was selected as one of only 20 museums in the UK to receive support from a national scheme. The 'Future Proof Museums' programme provides the museum with vital support from industry specialists who share their expertise to develop and enhance the services the museum is able to offer. Our service users have been involved in the scheme, sharing their views about how the museum should be developed.

Care Quality Commission inspection

The Trust received an inspection visit from the Care Quality Commission in March 2016. At the time of writing this report, we do not yet know the Trust's rating from the inspection. Verbal feedback received at the end of the visit provided a positive message that our staff were caring without exception. We are proud of this achievement. The Care Quality Commission also stressed how impressed they were with how we are responding to an extremely challenging environment while maintaining positive morale. They highlighted some notable areas of good practice that they had seen:

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

The Care Quality Commission also highlighted a number of areas of concern.

Safer staffing

The major concern was around the pressures on our staffing complements across acute mental health services and also made reference to the fact that demand and acuity were at a high level. At the time of initial feedback, the Care Quality Commission will not have had an opportunity to consider our safer staffing report, evidence-based staffing tool and other information from staff surveys.

Rehabilitation services

The concern here related to the multi-disciplinary team reviews/care planning approach across our service and the differences in practice between our two rehabilitation units. We will now need to look at how we can evidence the activity that takes place within the service and any additional information in respect of our monitoring approach that was not found at the time of the visit.

Mental Health Act and Mental Capacity Act training and recording of it taking place

The Care Quality Commission commented that they found many areas of positive practice across the Trust but it was not at a consistent level. They were concerned that the training was not mandatory and, therefore, the Trust might not have an accurate record of uptake. At the time of the initial feedback they would not have had the benefit of our code of practice and Mental Capacity Act/Mental Health Act training action plan where we had identified this, including a proposal to make the training mandatory.

Waiting lists for child and adolescent mental health services and psychological therapies
We remain concerned as they do, around waiting lists wherever they occur in our services and will be providing further information about the action we are taking, both internally and with our commissioners, in this respect.

Physical health monitoring
This is an area where we struggled to understand the comments made by the Care Quality commission as there have been significant pieces of positive work across the organisation. We will be providing them with further information to ensure that they have the best picture of our positive practice in this regard.

Working in partnership with our stakeholders

The Trust continues to work in partnership with its staff, stakeholders and partners. Key activity during 2015/16 has focussed on national initiatives, such as Vanguards (health and social care organisations coming together to develop new models of care) and development of Sustainability and Transformation Plans (health and social care organisations working in partnership to drive sustainable transformation in patient experience and health outcomes) on a regional footprint.

In Calderdale, we are working with partners in the upper valley to develop multi-speciality community provider arrangements, involving primary care though support for mental health liaison, clearer links between mental and physical health, and building capacity around Creative Minds and Recovery Colleges. In West Wakefield, we are working with partners to develop multi-speciality community provider arrangements to support transformation, providing health and wellbeing support and mental health navigators in locality hubs. Also, in Wakefield, we are involved in the care homes Vanguard, where we are part of a dedicated multi-disciplinary team supporting the needs of care home residents to promote person-centred care using our Portrait of a Life package. In the wider West Yorkshire footprint, we are part of the urgent and emergency care Vanguard aimed at making the best use of the acute mental health bed-base, and to develop and refine crisis care arrangements, including police and psychiatric liaison, working in partnership with the two other mental health trusts in West Yorkshire.

We are also involved in the development of an Accountable Care Organisation across Barnsley

Quality and quality governance

Our commitment and approach to quality is at the very heart of what we do. Our approach to quality is set out in our Quality Improvement Strategy, which brings together national policy, strategic direction and regulatory, financial and governance requirements with our aim to provide 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. This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The Trust has also signed up to the national ‘Sign up to Safety’ initiative and will deliver against a specific safety improvement plan over the next three years.

The 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 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 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 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.

Although our quality priorities have remained consistent over the past three years, the quality initiatives we undertake against these priorities can change from year-to-year. This means we are not always able to directly compare our performance against each priority each year, as we are not comparing 'like for like'.

Throughout 2015/16 we measured activity against each of our quality priorities and reported them to our Clinical Governance and Clinical Safety Committee. Our progress against these priorities can be found below. Our Quality Accounts provide a more detailed review of our performance over the year as well as setting out our priorities for the year ahead.

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	

Challenging performance indicators are in place against each priority. We have maintained a good standard of performance against the majority of indicators. Overall, we have achieved 71% of the key performance indicators we identified in 2015/16 and, in a further 20% of cases, we were within 10% of achieving the goal. This is an overall increase in performance against achievement of priorities in 2014/15, when we achieved 66% of key performance indicators with 24% partially met and 18% not met.

We have achieved high performance in the areas of access to services, recording care, care pathways and safety. The area of focus in 2016/17 will be care planning where we have not met our goals. We will continue to monitor areas where we have underperformed and review our processes to ensure all risks have a mitigation plan. For each quality improvement area, there is a clear organisational leadership processes so the Trust can monitor and review progress in each area. Further detail of our achievements can be found in 'Part 3 - Our Performance in 2015/16' in our Quality Accounts.

In the friends and family tests, 90% of our patients in community services and 80% of our patients in mental health services would recommend us to friends and family.

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 and a proportion of our income is conditional on achieving these. The Trust met 88% of its quality innovation goals in 2015/16 and an overall total of £4.5 million was available. By comparison an overall total of £4.6 million was available in 2014/15 and a total of £4.4 million (90%) was achieved.

Our performance

In addition to measuring performance against our quality priorities, our Board identified a number of key performance indicators (KPIs) for 2015/16 relating to key areas of Trust activity. These represent a mix of nationally and locally set targets.

Business Strategic Performance – impact and delivery			
	KPI	**Target**	**Month 12 position**
Monitor compliance	Monitor governance risk rating	Green	Green
	Monitor continuity of services rating	Green/4	Green/4
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
Infection prevention	Infection prevention (MRSA and C Diff cases)	6	3
C-Diff	C-Diff preventable cases	0	0
Outcomes	% service users on CPA in employment	10%	7.25%
	% of service users in settled accommodation	60%	69%

We currently achieve all KPIs set by our regulator, Monitor, with the exception of the 'improving access to psychological therapies standard (first treatment within six weeks)' (IAPT) target and 'meeting commitment to serve new psychosis cases by early intervention teams'. In terms of IAPT, since first reported in Q3 2015/16, our performance has been positive; however, we have experienced ongoing recruitment difficulties in respect of appropriately trained staff. Remedial action is in place and this will positively impact on new patients entering the service; however, a risk remains for patients already in treatment. In terms of early intervention services (EIP), we narrowly missed this target in Q4 (94.14% against a target of 95%) due to a re-focus of team activity to ensure the new EIP target is achieved from this quarter. The Trust does not believe the underperformance in this target impacts negatively on the quality of the service we deliver.

Operational effectiveness: process effectiveness (Monitor)			
	KPI	**Target**	**Month 12 position**
Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment – non-admitted	95%	96.9%
	Max time of 18 weeks from point of referral to treatment – incomplete pathway	92%	98.1
	Delayed transfers of care (DToC)	< = 7.5%	2.3%
	% admissions gatekept by Crisis teams	95%	98.3%
	% SU on CPA followed up within 7 days of a discharge	95%	97.4%
	% SU on CPA having formal review within 12 months	95%	96.6%
	Meeting commitment to serve new psychosis cases by early intervention teams	95%	94.1%
	Data completeness: community services – referral to treatment	50%	100%
	Data completeness: community services – referral information	50%	96.8%
	Data completeness: community services – treatment activity information	50%	96.8%
	Data completeness: identified (mental health)	97%	98.5%
	Data completeness: outcomes for patients on CPA	50%	75.6%
	Compliance with access to health care for people with a learning disability	Compliant	Compliant
	IAPT – treatment within 6 weeks of referral	75%	70.5%
	IAPT – treatment within 18 weeks of referral	95%	98.1%
	Early intervention in psychosis – 2 weeks clock stops	50%	86%
Data quality	% valid NHS number	99%	99.7% *
	% valid ethnic code	90%	94.6% *

* Month 11 figures

Customer focus			
	KPI	**Target**	**Month 12 position**
Complaints	% complaints with staff attitude as an issue	<25%	15% 31/211
Service user experience	Friends and Family Test		87.2%
Managing aggression and violence	Physical violence (against patient by patient)	14-20	Above ER
	Physical violence (against staff by patient)	50-64	Above ER
Freedom of Information	% of requests for information under the act processed in 20 working days	100%	100% 75/75
Befriending services	% of service users requesting a befriender assessed within 20	80%	100%

Customer focus			
	working days		
	% of potential volunteer befriender applications processed within in 20 working days	90%	100%

Fit for the future: workforce			
	KPI	**Target**	**Month 12 position**
Sickness	Sickness absence rate (YTD)	4.4%	5%
Appraisal	Appraisal rate Band 6 and above	95%	97.5%
	Appraisal rate Band 5 and below	95%	96.9%
Mandatory training	Aggression management	80%	83.2%
	Equality, diversity and inclusion	80%	92.2%
	Fire safety	80%	86.7%
	Food safety	80%	78.4%
	Infection prevention and control and hand hygiene	80%	87.6%
	Information governance	95%	96%
	Safeguarding adults	80%	90.2%
	Safeguarding children	80%	90%
	Moving and handling	80%	85.6%
Safer staffing	Safer staffing – full rate (nurses)	90%	94.1%
	Safer staffing – full rate (health care assistants)	90%	117.4%

Our financial performance 2015/16

This section and the accounts have been prepared in line with appropriate guidance, including the Annual Reporting Manual for NHS Foundation Trusts 2015/16 and under 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. The Trust continues to prepare 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.

The Trust had an annual turnover of £229.8 million for 2015/16 and an overall surplus of £0.2 million (0.1%) for the year. Of its total income, 73% is generated by healthcare contracts with local Health commissioners (Clinical Commissioning Groups (CCGs) in Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield) and 5% from local authorities. The Trust also has healthcare contracts with NHS England and other third parties. The majority of contract income is commissioned as a fixed payment; however, 2.5% (£4.5 million for 2015/16) is based on the achievement of key quality indicators. The Trust achieved 78% of the performance indicators.

We met our requirements set out in our annual plan for 2015/16.

Income & Expenditure Performance for 2015/16		
	2015/16	**2014/15**
	£'000	£'000
Income from Activities	213,233	221,227
Other Operating Income	16,604	16,450
Total Income	229,837	237,677
LESS		
Operating Expenses	(226,729)	(231,883)
Interest Received	89	95
Public Dividend	(2,990)	(2,793)
Movement in fair value of investment properties	0	16
Surplus	207	3,112

Our financial performance is scored by Monitor using the Continuity of Service Risk Rating. The score in our annual plan was 4 and we achieved a score of 4 in each quarter of 2015/16. The maximum score achievable is 4.

The Trust achieved a savings target of £8.3 million during the year. This represented a shortfall in delivery of £1.4 million in year (target £9.7 million). This position was achieved with £5.7 million (59%) delivered as set out in the original programme and £2.6 million (27%) through mitigations and substitutions.

Our capital budget was reviewed in detail, as requested by Monitor, and was revised in-year from the initial £12 million to £11.5 million. This reduction focussed on expenditure on information management and technology and ensuring value for money was secured. Overall actual expenditure was £11.3 million which is a £0.2 million (2%) variance compared to the revised plan. Notable schemes completed in-year include the opening of two new community hubs in Calderdale and Barnsley. Work on two further hubs in Wakefield and Pontefract has begun and is expected to complete in 2016/17. Next year will also see the commencement of significant capital investment in non-secure in-patient facilities on our Fieldhead site.

We planned and maintained a healthy cash balance throughout the year with a balance of £27.1 million as at 31 March 2016. These cash funds have been built up over time to fund 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, we are able to generate income by investing cash. During 2015/16, the Trust has invested only with the National Loan Fund (NLF). This is a low risk form of investment (when compared to other commercial alternatives) but provides a higher rate of return than maintaining all cash balances within the Government Banking Service (GBS).

The Trust manages its working capital balances making payments on due dates in line with the NHS Better Payment Practice Code. As at March 2016, 91% of NHS and 96% of non-NHS invoices have achieved the 30 day payment target of 95%.

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 applied in 2015/16. These 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 2015/16 accounts.

Valuation of assets

In line with the Trust's Accounting Policies, a periodic review of Trust estate has been conducted in 2015/16. 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 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 2016, this related to one Trust asset.

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.

Auditor's remuneration
Audit fees were £51,672. This covers both the annual report and accounts, and the Quality Accounts. The fee for independent examination of the charitable fund was £828. A further £20,000 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 as to disclosure to auditors
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.

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 2015, the latest year for which information is available, on the Trust's website. The annual report for 2015/16 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.

Sustainability

We have continued to develop our approach to sustainability through delivery of an agreed strategy. The strategy sets out realistic, measurable targets under each of the three national goals and each of the Good Corporate Citizen assessment headings. Areas of specific focus 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. The strategy is delivered through a clear framework that operates across all of our operational service delivery.

We continue to use the Good Corporate Citizenship model which mirrors Trust values and 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.

The Trust's current assessed score using the Good Corporate Citizenship model is 78%, which compares favourably when benchmarked against other organisations that have elected to undertake self-assessment. The main area for improvement is around transport, travel and access and a green travel plan is under development, covering transport planning, transport services, fleet management, agile working, service user experience and links to estates strategy.

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. We monitor the use of local SME (Small, Medium Enterprises) suppliers and work proactively to maintain and increase engagement with these organisations. The level of SME activity is a specific and measurable performance indicator. Any contracts which are tendered are conducted through the Trust's eTendering portal and are advertised on '*Contracts Finder',* the recommended website for advertising public sector contract opportunities to the local community suppliers. Full support is offered to SMEs to ensure equality of opportunity in responding to tenders. In addition, all tenders include a section on sustainability, which requests the submission of a statement from the bidder on their organisation's position linked to the Good Corporate Citizen concept.

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 equality impact assessments to ensure our services take account of need, especially where services are developing and changing. We have also progressed work to embed the equality objectives based on the four equality goals from the Equality Act 2010 and the Department of Health's Equality Delivery System 2 (EDS2). These are better health outcomes for all, improved patient access and experience, empowered, engaged and well-supported staff, and inclusive leadership at all levels.

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, in our approach and in our workforce, we will be able to meet the positive challenges associated with equality in the 21st century and maximise people's potential.

The Trust has human resources policies in place, which can be found on the Trust's website, which promote equality of opportunity in employment. For example, a policy is 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.

This year we reviewed and refreshed the equality, diversity and inclusion training we deliver face-to-face for staff following input from Professor Uduak Archibong from the Centre of Diversity and Inclusion at Bradford University. Staff can now access three tiers of training relating to knowledge and understanding, practical application of best practice, and specialist advice and consultancy. Numbers of staff who attend this training are continuing to grow.

Looking ahead

Our strategic objectives in 2016/17 will focus on three aims to improve outcomes for the communities we serve, to improve the effectiveness and quality of our interventions working with partners, and to improve our use of resources. This will be based on key service priority areas relating to children and young people, better integration of mental and physical health, urgent care, prevention and primary intervention, and forensic services with cross-cutting themes relating to leadership, use of technology, safety, access and workforce.

The Trust's plan for 2016/17 sets out a recurrent underlying surplus of £1.2 million with an in-year planned surplus of £500,000. This planned surplus is lower than the control total of £1.2 million set by NHS Improvement. Our approach to the control total is that we will endeavour to work towards it subject to our Board being satisfied it can be delivered without compromising patient safety. Following the recent Care Quality Commission inspection, the Trust has prioritised investment in safer staffing and identified a sum of £750,000 to ensure continued safety of services. This has directly affected our ability to deliver the control total. This position results in an income and expenditure margin rating of 3 for the Trust.

Achievement of our planned surplus of £500,000 means that we will need to deliver a challenging cost improvement in 2016/17. Our financial plan assumes cost savings of £10 million. All are subject to a quality impact assessment and significant programmes will be established with robust project management arrangements. Significant areas of our savings are in direct response to the recommendation in the Carter Productivity Review and include:

- a productivity review of older people and community services;
- a comprehensive review of Trust management costs;
- an extensive review of Trust non-pay contracts through effective re-procurement of services;
- a review of contracts for pathology and radiology; and
- a review of prescribing and medicines management to reduce Trust drug costs.

In addition, we are undertaking a focused review of Trust services to maximise the benefits of service standardisation across our geography, a comprehensive review of all service and

support budgets, development of a peripatetic staffing pool to minimise the reliance on agency staff with the Trust and reduction in out-of-area placements.

Rob Webster
Chief Executive
23 May 2016

SECTION 2 – ACCOUNTABILITY REPORT

Section 2.1 Directors' report

This section of our annual report supports the performance report setting out our governance arrangements and how these have operated over the last year. The framework for these 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 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 Annual Reporting Manual and other disclosures as appropriate.

The Directors of the Trust consider the annual report and accounts, taken as a whole, are fair, balanced and understandable, and provide the information necessary for people who use our services, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

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 and their carers 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.

Trust Board has a variety of individual skills and experience, which Directors bring to bear on the work of the Trust. Each director's experience is described below. Information on Directors' interests as at 31 March 2016 can be found on the Trust's website.

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 2016 is as follows.

	Total	Male	Female
Non-Executive Directors	7	4 (57%)	3 (43%)
Executive Directors	6	5 (83%)	1 (17%)
Other Directors	6	1 (17%)	5 (83%)

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. The outcome of the Chair's appraisal for 2015/16 will be reported to the Members' Council at its meeting in July 2016.
- 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 previous 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	Experience	Board attendance
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	➢ 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 charity ➢ Variety of charitable interests nationally and locally, including blood bikes ➢ Non-Executive Director, Benenden Insurance ➢ Chair, Keegan and Pennykid Insurance Brokers ➢ Non-Executive Director, Seedrs (FSA authorised internet crowdfunding investment) ➢ Experience as a school governor, pension fund trustee and FE college governor ➢ Formerly chair and treasurer of Scope (UK disability charity).	8/8
Non-Executive Director **Laurence Campbell**  Appointed 1 June 2014	➢ 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. ➢ Treasurer and Trustee of Kirklees Citizens Advice and Law Centre	8/8
Non-Executive Director **Rachel Court**  Appointed 1 October 2015 to 30 September 2018	➢ 23 years' experience at Yorkshire Building Society involving a wide range of roles including operations, customer service, risk management, sales, product development, HR, staff engagement and communications. ➢ The last 8 years were spent as a member of the Executive Team responsible for the overall strategy of the organisation, and involved overseeing 4 successful mergers and integration projects with other organisations and major programmes of organisational change. ➢ Other current NED, charitable & voluntary roles include Chair – NHS Pension Board, NED – Leek United Building Society, including Chairing Remuneration Committee and being a member of Risk Committee, NED – Invesco Perpetual Pensions Ltd, including being a member of Risk Committee, Governor – Calderdale College. ➢ Magistrate in Calderdale ➢ Chair – PRISM – a Charity providing alternative education to children excluded from mainstream schooling	4/4

Role/name/appointment	Experience	Board attendance
Non-Executive Director **Charlotte Dyson**  Appointed 1 May 2015 to 30 April 2018	➢ Marketing Consultant ➢ Formerly Non-Executive Director for Calypso Soft Drinks ➢ Formerly Non-Executive Director Leeds Teaching Hospital ➢ Particular area of expertise in strategic brand marketing. ➢ Lay member for Royal College of Surgeons of Edinburgh and chair for Advisory Appointments Committee for Leeds Teaching Hospitals NHS Trust ➢ Member of the National and Local Advisory Committee for Clinical Excellence awards	7/7
Deputy Chair **Julie Fox**  Appointed 1 August 2011 to 31 July 2014 Re-appointed 1 August 2014 to 31 July 2017 Deputy Chair/Senior Independent Director from 1 August 2015 to 31 July 2017	➢ 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, Ofsted and the Care Quality Commission and equivalent Welsh inspectorates ➢ HR experience in recruitment and staff development ➢ Four years restaurant ownership	8/8
Non-Executive Director **Chris Jones**  Appointed 1 August 2015 to 31 July 2018	➢ Qualified accountant with previous experience in public and private sectors including the NHS ➢ Seven years as Principal and Chief Executive of Calderdale College ➢ Formerly a member of the Calderdale Safeguarding Children Board ➢ Trustee of Children's Food Trust ➢ Interested in leadership and governance and the impact on service standards and organisational performance	5/5

Role/name/appointment	Experience	Board attendance
Non-Executive Director **Jonathan Jones**  Appointed 1 June 2010 to 31 May 2013 Re-appointed 1 June 2013 to 31 May 2016 Re-appointed 1 June 2016 to 31 May 2017	➢ 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.	8/8
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) Retired 31 March 2016	➢ 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. ➢ Recognised by Health Service Journal 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.	8/8

Role/name/appointment	Experience	Board attendance
Chief Executive **Rob Webster**  Appointed 16 May 2016	➢ Joined Trust from the NHS Confederation, where he was chief executive for over two years. ➢ Worked in healthcare since 1990, including national roles at the Department of Health on policy, transformation and delivery and has been a director for both the Prime Minister's Delivery Unit in the Cabinet Office and a national public/private partnership. ➢ Also spent seven years as a successful chief executive in the NHS in West Yorkshire, running a commissioning organisation (NHS Calderdale) and a provider organisation (Leeds Community Healthcare NHS Trust). Has been a trustee at Leeds Mencap and has chaired formal national networks including cancer, primary care, community services and learning disabilities. ➢ As well as leading the Trust, is also leading the work of the West Yorkshire sustainability and transformation plan (STP), bringing together West Yorkshire health and care leaders, organisations and communities to develop local plans for improved health, care and finances over the next five years. ➢ Defined by a values-based approach to leadership with a history of effective partnership working and a strong commitment to system leadership. ➢ Visiting professor at the school of health and care at Leeds Beckett University and an honorary fellow of both the Queen's Nursing Institute and the Royal College of GPs. Also a fellow of the Royal Society for the encouragement of Arts, Manufactures and Commerce.	N/A
Medical Director **Adrian Berry**  Appointed Director of Forensic Services 1 November 2010 Medical Director 1 October 2014	➢ 19 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 ➢ Development of a Yorkshire Clinical Network for Forensic Services	8/8

Role/name/appointment	Experience	Board attendance
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	➢ Over 30 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	8/8
Interim Director of Finance **Jon Cooke**  Secondment (Yorkshire and the Humber Commissioning Support Unit) 4 January to 31 May 2016	➢ Qualified chartered management accountant with 22 years post qualification experience in the NHS ➢ Experience at a senior level across commissioning and provider organisations ➢ 4 years' experience as a Director of Finance working in Commissioning and Commissioning Support. Track record in strategic planning and delivery through innovation and joint working ➢ Significant experience of change management within the healthcare sector ➢ Experience in strategic financial planning and management, contract negotiation, development of estates and capital business cases (including establishment and delivery of NHS LIFT), developing IM&T Strategy and implementation of performance framework based on balanced scorecard, and implementation of integrated governance and change management ➢ Delivery of turnaround within NHS organisations	2/2
Director of Human Resources and Workforce Development **Alan Davis**  Appointed 1 April 2002	➢ 33 years' experience of HR in the NHS ➢ 19 years as an Executive Director of this 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	8/8

Role/name/appointment	Experience	Board attendance
(Interim Deputy Chief Executive 1 April to 31 August 2016)	➢ 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 **Alex Farrell**  Appointed Director of Finance 7 September 2009 Deputy Chief Executive/Director of Finance from March 2010 to 3 January 2016 Acting Chief Executive 1 October 2010 to 31 January 2011 Deputy Chief Executive from 4 January 2016 (Interim Chief Executive 1 April to 15 May 2016) (Retired 31 May 2016)	➢ Qualified medical doctor ➢ Re-trained 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 ➢ Ten 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. ➢ Bring 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.	8/8
Director of Corporate Development (Company Secretary) (non-voting) **Dawn Stephenson**  Secondment 8 February 2010 Substantive appointment from 1 April 2011	➢ 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.	8/8

Role/name/appointment	Experience	Board attendance
District Director – specialist services (non-voting) **Carol Harris**  Appointed 21 March 2016	➢ Broad clinical experience as a nurse in both inpatient and community settings ➢ Previous experience in professional and operational leadership at Board level ➢ Worked with service user and carer stakeholder groups in all aspects of service change ➢ Led a number of transformation programmes both within mental health services and working with acute and third sector providers ➢ Provided mentorship to candidates on leadership programmes ➢ Supported the development of the foundation degree programme for assistant practitioner trainees with Manchester Metropolitan University	N/A *
Director of Communications, Engagement and Commercial Development (non-voting) **Kate Henry**  Secondment 26 May 2015 to 31 March 2016 Fixed term contract 1 April 2016 to 30 June 2017	➢ Successful track record in health care communications, PR and marketing ➢ 13 years' NHS experience working in both local and national NHS organisations ➢ 8 years working in NHS marketing / communications / PR roles ➢ Experience in mental health, acute and improvement organisations ➢ Particular roles focusing on communicating biomedical research, improvement science, innovation, adoption and spread.	N/A *
District Director – Barnsley and Wakefield (non-voting) **Sean Rayner**  Transitional post as District Director, Barnsley from 22 February 2011 Substantive from 1 April 2012	➢ 25 years' experience in the NHS, with 12 years' experience as an Executive Director. ➢ Barnsley Transition Director in support of SWYPFT 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).	N/A *

Role/name/appointment	Experience	Board attendance
Director of Health Intelligence and Innovation (non-voting) **Diane Smith**  Interim appointment 9 January 2014 Substantive appointment 1 January 2015	➢ 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.	N/A *
District Director – Calderdale and Kirklees (non-voting) **Karen Taylor**  Interim appointment 9 January 2012 Substantive appointment 1 April 2012	➢ 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.	N/A *

* Only voting Directors and the Director of Corporate Development, in her role as Company Secretary, attend all Trust Board meetings.

The following members of Trust Board left office during 2015/16.

Name/role/appointment	Experience
Non-Executive Director **Peter Aspinall** Appointed as designate 1 November 2008 Substantive from 1 May 2009 to 30 April 2012 Re-appointed from 1 May 2012 to 30 April 2015	➢ 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.

Name/role/appointment	Experience
Deputy Chair/Senior Independent Director **Helen Wollaston** Appointed 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	➢ 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.
Interim District Director – specialist services (non-voting) **Nette Carder** Interim appointment 5 January 2015 to 25 March 2016	➢ 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

Well-led governance review

In 2014, Monitor stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years given that:

- good governance is essential in addressing the challenges the sector faces;
- oversight of the Trust's governance arrangements is the responsibility of Trust Board;
- governance issues are increasing across the sector; and
- regular reviews can provide assurance that governance arrangements are fit for purpose.

As a result, Monitor issued guidance to support Trusts in ensuring they are 'well-led'. The framework supports the NHS response to the Francis Report and is aligned with the assessment the Care Quality Commission makes on whether a foundation trust is well-led as part of its revised inspection regime. The framework has four domains, ten high-level questions and a description of 'good practice' that can be used to assess governance. The four domains cover:

- strategy and planning – how well the Board sets the direction for the organisation;
- capability and culture – whether the Board takes steps to ensure it has the appropriate experience and ability, now and into the future, and whether it positively shapes the organisation's culture to deliver care in a safe and sustainable way;
- process and structures – whether reporting lines and accountabilities support the effective oversight of the organisation; and
- measurement – whether the Board receives appropriate, robust and timely information and that this supports the leadership of the Trust.

Our Board decided to undertake the independent review of the Trust's governance arrangements early in 2015 and Deloitte was appointed to undertake the review in April 2015. Trust Board's decision to undertake an independent review at this time was part of the developmental approach the Board takes to its governance arrangements and to ensure fitness for purpose in the move to the next challenging phase.

Following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded that there were no 'material governance concerns'. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. There are a number of developmental areas where Deloitte has recommended further work and these form the basis of an action plan with timescales, which Trust Board is taking forward. It is anticipated that all actions will be complete by the end of May 2016 and internal audit will undertake a review of implementation as part of its audit work for corporate governance arrangements in 2016.

The process and outcome reflect the developmental approach taken and Trust Board is satisfied with the outcome. The Deloitte report very much reflects Trust Board's own assessment of the Trust's arrangements and the report identified a series of helpful and constructive areas for development around clear articulation of our strategic priorities and strengthening how these are communicated, clear monitoring and reporting against these, further development of the Board assurance framework, monitoring and assurance of the Trust's transformation programme, and strengthening and enhancing staff engagement.

Governance arrangements

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 are 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 during the 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 2016. The Committee provided assurance that Committees are effective and integrated and that risk is effectively managed and mitigated through the assurance that Committees are meeting the requirements of their Terms of Reference, that their work plans are aligned to the risks and objectives of the organisation, which are within the scope of their remit, and that they can demonstrate added value to the organisation.

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 2015/16

Peter Aspinall, Non-Executive Director (to May 2015)	Attended one out of one meetings
Laurence Campbell, Non-Executive Director and Chair of the Committee	Attended five out of five meetings
Chris Jones, Non-Executive Director (from October 2015)	Attended two out of two meetings
Jonathan Jones, Non-Executive Director	Attended five out of five meetings

The Audit Committee has a number of responsibilities in relation to financial reporting. These are set out below with information on how these have been addressed during 2015/16. There were no significant issues in relation to the financial statements during the year.

	Progress
The Committee has responsibility for approving accounting policies.	The Committee considered and approved minor changes to accounting policies at its meeting in February 2016. These changes were supported by the Trust's external auditor.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of	The Committee approved the annual report, accounts and Quality Accounts at its meeting on 22 May 2015 prior to submission to Monitor. This included the Trust's charitable funds. The Committee also approved the stand-alone annual report and accounts for charitable funds in

	Progress
Finance on the signing of the accounts and associated documents prior to submission.	October 2015. As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2014/15 and received the report for those charged with governance, which outlines the findings of the external audit (ISA 260). The Committee also reviewed the external audit report on the production of Quality Accounts for 2014/15. *(It should be noted that the scrutiny of the preparation, development and final content of the Quality Accounts is the responsibility of the Clinical Governance and Clinical Safety Committee.)*
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board, including any review of the adequacy of reporting. The Committee receives a regular report on treasury management and reviews the Treasury Management Strategy and Policy on an annual basis (February 2016). The Committee also receives a detailed report on procurement activity, which monitors non-pay spend and progress on tenders, and progress against the Procurement Strategy and associated cost improvement programme. The Committee's agenda includes a standing item to review progress towards implementation of service line reporting and currency development. This has included assurance on operational implementation and use from BDU Directors as well as, in October 2015, a review of the Trust's approach to pricing, which was supported by the Committee. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. This was considered at its meeting in April 2015. The Committee asked for further assurance regarding the data used to compute the costs and was assured regarding the principles and standards. A further report on the work to improve the quality of clinical data was received in October 2015. Although the Committee has residual concerns regarding data quality, it has been reassured with regard to the management action in place. The Committee received and reviewed the Use of Resources Assessment for 2014/15.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;	The Committee received a proposal relating to the Scheme of Delegation following a concern that levels of approval and escalation in relation to procurement and tendering appear to be low in value in comparison with other NHS organisations. The Committee supported the conclusion form the Interim Director of finance

	Progress
	that there will not be any recommendation to change the current position as it does not cause major difficulties in terms of Trust processes. The Committee will receive a formal paper to endorse this approach in April 2016. There is an ongoing review of the overarching Scheme of Delegation, which will be presented to Trust Board in April 2016 for approval. Any resultant impact on the Trust's Standing Orders, Standing Financial Instructions and Constitution will be presented to Trust Board for approval.
- examines circumstances associated with each occasion Standing Orders are waived;	There were no occasions when Standing Orders were waived in 2015/16.
- reviews the schedules of losses and compensations on behalf of Trust Board.	The losses and special payments report is received by the Committee at each meeting.

As part of its external audit plan, Deloitte outlined the following significant audit risks as part of its review of the 2015/16 financial statements. The management response is also included for information.

Revenue recognition in respect of Commissioning for Quality and Innovation (CQUIN) income.
Further testing has reduced the risk originally identified.

Property re-valuation (the valuation of the Trust's £100 million of property assets (as at 31 March 2015) is inherently judgemental.
The valuation of Trust property continues to be undertaken by an independent and appropriately qualified external company. 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 reviewed by external audit.

Laura Mitchell House and New Street brought into use.
The Trust has noted and is aware of the risk identified in relation to the technical issues of capitalisation and depreciation.

Management override of controls.
The Interim Director of Finance was content that this was highlighted as a risk; however, the Trust retains a prudent approach to its accounting practice.

Agresso software upgrade.
Following the issues with the implementation of the upgrade to the Trust's clinical information system, RiO, the upgrade has been deferred to June 2016. It will not, therefore, be identified as a risk in 2015/16; however, Deloitte will review the risk posed by the issues encountered during the implementation of RiO V7 and the potential impact on the Agresso upgrade.

The Audit Committee has a number of responsibilities in relation to the Trust's external auditor. These are set out below with information on how these have been addressed during 2015/16.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Following a re-procurement exercise during 2015, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2015 for a period of three years. The Lead Governor for the Members' Council

	Progress was 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 Audit 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 (February 2016). Progress against the plan is monitored at each meeting.
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee structure for Deloitte was approved as part of the re-appointment process in 2015. For the Trust's audit, the fees for 2015/16 were £51,672 (2014/16 £56,000) and the independent examination of the Trust's charitable funds were £828 (2014/15 £2,000). A formal audit plan was presented to and approved by the Committee in February 2016. This included an evaluation of risk, which is summarised above.
Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: ➢ the statement for those with responsibility for governance in relation to 2014/15 accounts; ➢ final reports and recommendations as scheduled in the annual plan.
Develop and implement a policy on the provision of non-audit services by the External Auditor.	This is scheduled for development and presentation to the Committee in July 2016. The Trust's external auditor, Deloitte, was commissioned to undertake work in addition to its external audit activity. - Deloitte was 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 (£59,054). - Deloitte was commissioned to undertake an independent review of the implementation of the upgrade to the Trust's clinical information system, RiO (£15,000). 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. Deloitte was also asked 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 (£20,000). This piece of work was undertaken by the audit team Director.

The Audit Committee has a number of responsibilities in relation to the Trust's internal audit and counter fraud functions. These are set out below with information on how these have been addressed during 2015/16.

Internal audit	**Progress**
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	The Committee agreed an extension to the contract for KPMG as the Trust's internal auditors for one year (to 30 June 2016) and has considered its approach to internal audit and counter fraud services beyond this date. In

Internal audit	Progress
	February 2016, the Committee approved a further extension to KPMG's contract to 30 June 2017 given the changes within the organisation at a senior level and the desire to minimise unnecessary risk to the Trust. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal Auditing Standards and KPMG's own Internal Audit Manual. This was approved by the Committee in July 2015.
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.	The Internal Audit Annual Plan for 2015/16 was presented to and approved by the Committee in April 2015. 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 internal audit. 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. From April 2015 to February 2016, thirteen internal audit reports were presented to the Committee. Of these, there were: - two significant assurance opinions; - six significant assurance with minor improvement opportunities; - four partial assurance reports (management of service level agreements, information governance toolkit (phase I), patients' property follow up and bed management); and - no 'no' assurance opinion. An opinion for the audit of quality improvement was taken in two parts. The Quality Improvement Strategy received an opinion of significant assurance with minor improvement opportunities and data quality received a partial assurance opinion. 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 an ongoing concern regarding data quality within the Trust. At its request, the Committee received a presentation from the Deputy Director of

Internal audit	Progress
	Nursing in October 2015 to seek assurance that the Trust has taken sufficient and adequate management action to improve the quality of clinical information. A further update was provided to the Committee in February 2016. The Committee was assured by both presentations but this will remain as an item on the Committee's agenda. The Committee also asked the Executive Management Team to review the findings of the patients' property audit to ensure ownership and improvement given the concerns raised by the Chair of the Committee at the meeting in October 2015. An update on progress to implement the recommendations was provided to the Committee in February 2016. The Committee appreciated the positive response and noted there were a few additional areas still to address. It was suggested a return visit by internal audit in three months. The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2014/15. This provided significant assurance with minor improvement opportunities.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year although there are some residual issues raised by the Director of Finance in relation to the scoping and planning of audit work.
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. Performance against these is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report, received in May 2015.

Counter fraud	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	The Trust's contract for internal audit services with KPMG includes provision of counter fraud services.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	KPMG presented a programme of work to the Committee in April 2015, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action. The Trust undertook a self-assessment against NHS Protect's Standards for Providers, the outcome of which was reported to the Committee in July 2015. The Trust achieved an amber rating, which demonstrates that the Trust meets the standards and had no red ratings. The review had been cross-referenced with the external assessment reported in October 2013 and there was only one area of potential mis-match in relation to proactive liaison with other

Counter fraud	Progress
	organisations and agencies. The Trust will raise with NHS Protect the question of whether it could be included in NHS Protect protocols with other organisations. The outcome against the standards has also been used as a baseline to prioritise counter fraud activity supported by responses to the staff counter fraud awareness survey, which will be built into the counter fraud annual plan. In February 2016, the Committee received a further update following a review by KPMG. In the main, the ratings remain as in July 2015 with no red ratings. An action plan is in place, which will be monitored by the Committee during 2016.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received an annual report for 2014/15 in July 2015.
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.

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.

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.

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 2015/16

Ian Black, Chair of the Trust	Attended two out of six meetings
Charlotte Dyson, Non-Executive Director (from September 2015)	Attended three out of three meetings

Julie Fox, Non-Executive Director (Chair from September 2015)	Attended six out of six meetings
Helen Wollaston, Non-Executive Director (Chair to June 2015)	Attended three out of three meetings
Adrian Berry, Medical Director	Attended six out of six meetings
Tim Breedon, Director of Nursing, Clinical Governance and Safety (lead Director)	Attended five out of six meetings
Alan Davis, Director of Human Resources and Workforce Development	Attended six out of six meetings
Dawn Stephenson, Director of Corporate Development (in role as Company Secretary)	Attended four 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 Standards.

Julie Fox, Non-Executive Director (Chair)	Attended four out of four meetings
Chris Jones, Non-Executive Director (from November 2015)	Attended one out of two meetings
Jonathan Jones, Non-Executive Director	Attended two out of four meetings
Helen Wollaston, Non-Executive Director (to May 2015)	Attended one out of one meeting
Adrian Berry, Medical Director	Attended three out of four meetings
Tim Breedon, Director of Nursing, Clinical Governance and Safety (lead Director)	Attended three out of four meetings
Dawn Stephenson, Director of Corporate Development (in role as Company Secretary)	Attended three out of four meetings

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 Forums

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.

Equality and Inclusion Forum

The Equality and Inclusion Forum was established by Trust Board in May 2015 and its prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Forum is chaired by a Non-Executive Director and has Non-Executive and Executive Director membership.

Quality governance reporting

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, 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.

More information on the Trust's approach to quality governance and its performance against its quality priorities can be found in Section 1 of this report and in the Trust's quality accounts for 2015/16.

The arrangements for internal control can be found in the Chief Executive's annual governance statement later in this report. Both the Statement and the Board assurance framework are subject to independent review. An assessment by internal audit found the Trust's arrangements around the assurance framework and its risk management processes provided significant assurance and the Head of Internal Audit Opinion is one of significant assurance with minor improvement opportunities given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

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

Section 2.2 Remuneration report

Annual statement on remuneration

The Trust's remuneration policy remains that the terms and conditions for staff reflect nationally determined arrangements under Agenda for Change. 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 Remuneration and Terms of Service Committee.

In 2014/15, the Trust introduced a local Clinical Excellence Award Scheme based on the previous national employer-based awards scheme. This has continued in 2015/16. The local Scheme is designed to promote and reward medical excellence linked to delivery of the Trust's strategic goals and contribution to leadership and management arrangements remains.

The Chair of the Remuneration and Terms of Service Committee is able to confirm that, during 2015/16, there were no major decisions on senior managers' remuneration and no substantial changes in-year.

For the purposes of the annual report, the definition of "senior managers" is "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust". The Chief Executive has confirmed that this includes the Chair, Non-Executive Directors, Executive (voting) Directors and non-voting Directors.

Senior managers' remuneration policy

The Trust's approach to the remuneration policy for its Executive Directors is that it is fair, justifiable and transparent enabling the Trust to recruit and retain high calibre personnel to achieve its aims and objectives. The Remuneration and Terms of Service Committee is responsible and has delegated authority from Trust Board to set the pay and conditions of senior managers within the Trust and this is subject to regular review and benchmarking by an external, independent remuneration specialist.

The Committee took the decision in November 2015 to align non-voting Directors' remuneration with Band 9 under Agenda for Change in light of national developments in relation to Very Senior Managers' pay. From 1 April 2016, all non-voting Director appointments will reflect this arrangement. Existing non-voting Directors' remuneration will be assimilated to mirror the payscale. Other terms and conditions for Executive and other Directors are in line with national arrangements under Agenda for Change with the exception that Executive and non-voting Directors are not awarded automatic incremental progression on their salary scale but are subject to earned remuneration linked to the performance related pay scheme.

The package for senior managers is made up of salary, pension and a performance related pay scheme (if eligible). The information contained on pages 40 and 41 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 2015/16.

The Chief Executive and the Medical Director are the only senior managers paid over £142,000. The Remuneration and Terms of Service Committee considers both to be reasonable as the Chief Executive's salary is independently evaluated on a regular basis, is consistent with the Trust's remuneration policy and is benchmarked against peers within the

NHS. The Medical Director's salary is based on and benchmarked against comparative organisations.

Following a change to national arrangements under Agenda for Change, the Committee approved a proposal to continue to mirror the Agenda for Change redundancy arrangements for Directors with a locally-determined salary cap based on the principle of 80% of the highest salary.

Details of appointment dates for Executive Directors of the Trust are included in the table under the Directors' report in section 2.1 above. There are no Executive Directors appointed on fixed term contracts; therefore, there are no unexpired terms and contracts do not contain provision for early termination of a contract. All Executive Directors are subject to a six-month notice period, which was considered and approved by the Remuneration and Terms of Service Committee in February 2015. The notice period for other Directors remains as three months.

	31 March 2016	31 March 2015
Band of highest paid Director's total remuneration (£000's)	185-190	170-175
Median total remuneration* £'s	27,480	27,306
Remuneration ratio	6.7	6.4

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.

Non-Executive Director remuneration

There has been no change to the remuneration of Non-Executive Directors during 2015/16. Remuneration remains at £13,250 per annum against an expected time commitment of at least 2.5 to 3 days per month. This was approved by the Members Council in April 2014.

Following an independent review of Chair remuneration undertaken by CAPITA, the Members' Council considered a proposal to establish an incremental scale for the position of Chair of £42,500/£45,000/£47,500/£50,000/£52,500 per annum with movement within the scale based on performance informed by the Chair's annual appraisal. This was approved by the Members' Council in July 2015. At the same time, the Members' Council approved a proposal to move the current Chair to the next incremental point of £50,000 per annum from 1 May 2015 based on his performance appraisal and the decision taken by the Members' Council to re-appoint him as Chair for a further three years.

Details of appointment dates for Non-Executive Directors of the Trust are included in the table in the Directors' report at section 2.1 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.

Performance related pay scheme

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

The Scheme for 2015/16 comprises two elements. Firstly, four corporate gateway 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 four elements of the gateway objectives are as follows.

1. Effective financial management and planning (the Trust achieves a minimum Monitor financial risk rating of 3 or above).
2. Effective governance, maintaining compliance and service quality (outcome of Care Quality Commission inspection, 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).
3. Service transformation, which should progress in line with timescales agreed by the Trust Board with a specific link to the integrated Business Plan.
4. Staff and stakeholder engagement, which would be based on the outcome of staff wellbeing and engagement surveys, feedback from external stakeholders, including from the well-led review, and service user and carer feedback.

The overall maximum performance award for a Director is 10% of base salary with 5% available for gateway objectives and 5% for personal objectives; however, the Committee took the decision that no award could be made if the Trust did not achieve 'good' or above for its Care Quality Commission inspection.

The gateway award has three levels as follows.

- Level 1: achievement of all four gateway objectives would realise a performance award of 5% plus individual awards of up to 5%;
- Level 2: achievement of three gateway objectives would realise a performance award of 2% plus individual awards of up to 5%; and
- Level 3: achievement of two gateway objectives would realise a performance award of 1% plus individual awards of up to 5%.

No award will be made if only one gateway objective is achieved.

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 are assessed by the Chair.

Directors eligible for the 2015/16 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 and Kirklees, the Director of Corporate Development, and the Director of Health Intelligence and Innovation.

The Committee agreed that, if a new director joins the Trust part-way through the year but before 1 October 2015, they would be eligible to join the Scheme with an award pro-rated to the number of completed months. Directors must have completed at least six months and remain employed by the Trust on 31 March 2016. Directors who leave prior to 31 March 2016 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 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 four gateway objectives are achieved, and the total performance awards for all eligible directors cannot exceed 4.5% of the eligible directors' paybill where only three of the four gateway objectives are met.

The Chief Executive informed the Committee in March 2016 that it was likely that gateway objectives 1 and 4 would be achieved. Further consideration would be given to objective 3 and objective 2 is dependent on the outcome of the Care Quality Commission inspection. The Committee also considered the Chief Executive's assessment of individual Director performance and recommended awards. These will be considered by the Committee when the outcome of the Care Quality Commission inspection is known in May/June 2016.

We are required to indicate in our annual report the expenses paid to our directors in the financial year and the sum paid in 2015/16 was £12,837.48 to sixteen directors (against a total of £11,461.56 in 2014/15 to eleven directors).

Annual report on remuneration

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
Rachel Court, Non-Executive Director (from October 2015)	Attended three out of four meetings
Jonathan Jones, Non-Executive Director	Attended six out of seven meetings
Helen Wollaston, Non-Executive Director (to July 2015)	Attended three out of three meetings
Steven Michael, Chief Executive (non-voting member)	Attended six 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. The Chief Executive's appointment is 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. No other external support of advice, whether from an individual or organisation, was sought by the Committee during the year.

Nominations Committee

The Nominations Committee is a sub-group of the Members' Council, chaired by the Chair of the Trust, and the majority of members are governors. The Chief Executive is also a member of the Committee and the Director of Corporate Development attends in her role as Company Secretary. The Committee's 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 twice in the period covered and its membership was as follows.

Marios Adamou, Members' Council (staff election – medicine and pharmacy)	Attended none out of two meetings
Ian Black (Trust Chair) Chair of the Committee	Attended two out of two meetings
Nasim Hasnie, Members' Council (publicly elected – Kirklees)	Attended one out of two meetings
Ruth Mason, Members' Council (appointed – Calderdale and Huddersfield NHS Foundation Trust)	Attended two out of two meetings
Steven Michael (Trust Chief Executive)	Attended one out of two meetings
Michael Smith, Members' Council (publicly elected – Calderdale)	Attended two out of two meetings
Tony Wilkinson, Members' Council (publicly elected – Calderdale)	Attended one out of two 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. For Chair and Non-Executive Director appointments, the Committee will:

- review the balance of skills, experience and knowledge on the Board to ensure it remains fit for purpose, taking 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;
- consider whether to work with an external organisation to identify candidates with appropriate skills and experience required for such vacancies;
- with the support of an external organisation, if appropriate, identify suitable candidates through a process of open competition, which takes account of the above approach and the skills and experience required, which are set out in a clear person specification and in information for potential candidates to support the appointment process.

Following the appointment during 2015 of three new Non-Executive Directors (approved by the Members' Council in April 2015), the Nominations Committee considered a proposal from the Chair of the Trust to seek the re-appointment of Jonathan Jones for a further year when his term of office ended on 31 May 2016 given the exceptional circumstances facing the Trust with the changes at senior level within in the organisation. This was approved by the Members' Council in February 2016.

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 2015/16 were: Ian Black (Chair of the Committee, Chair of the Trust), Jonathan Jones (Non-Executive Director of the Trust), Helen Wollaston (to July 2015) (Non-Executive Director of the Trust), Rachel Court (from October 2015) (Non-Executive Director), Steven Michael (Chief Executive) (non-voting member) 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	31/03/2016						
	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	13.0			1.5		55 - 60
Peter Aspinall, Non-Executive Director (left 30/04/15)	0 - 5				0.4		0 - 5
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director (left 31/07/15)	5 - 10				1.5		5 - 10
Julie Fox, Non-Executive Director	15 - 20				1.3		15 - 20
Laurence Campbell, Non-Executive Director	15 - 20				0.6		15 - 20
Charlotte Dyson, Non-Executive Director (from 01/05/15)	10 - 15				1.2		10 - 15
Rachel Court, Non-Executive Director (from 01/10/15)	5 - 10				0.6		5 - 10
Christopher Jones, Non-Executive Director (from 01/08/15)	5 - 10				0.4		5 - 10
Steven Peter Michael, Chief Executive (left 31/03/16)	170 - 175	2.2	10 - 15		0.7	0	185 - 190
Alan George Davis, Director of Human Resources and Workforce Development	105 - 110	1.5	5 - 10			0	115 - 120
Alexandra Farrell, Deputy Chief Executive (and Director of Finance to 31/12/15)	120 - 125		5 - 10		0.3	0	130 - 135
Dawn Stephenson, Director of Corporate Development	80 - 85	23.3	5 - 10		0.7	0	110 - 115
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	105 - 110	1.0	5 - 10		0.2	2.5 - 5.0	120 - 125
Adrian Berry, Medical Director	35 - 40	2.9		115 - 120	1.1	195.0 - 197.5	350 - 355
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		5 - 10			0	105 - 110
Karen Taylor, District Service Director, Calderdale and Kirklees	95 - 100		5 - 10		1.3	0	105 - 110
Nette Carder, Interim District Director, CAMHS and forensic services (left 25/03/16)	170 - 175						170 - 175
Diane Smith, Director of Service Innovation and Health Intelligence	90 - 95		5 - 10		0.7	12.5 - 15.0	110 - 115
Carol Harris, Director of Forensic and Specialist Services (from 21/03/16)	0 - 5					2.5 - 5.0	5 - 10
Kate Henry, Interim Director of Marketing, Engagement and Commercial Development (from 05/05/15)	85 - 90						85 - 90
Jon Cooke, Interim Director of Finance (from 04/01/16)	35 - 40						35 - 40

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	0	95 - 100
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	0	105 - 110
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100		0 - 5		1.4	0	100 - 105
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					0	20 - 25

	31/03/2016	31/03/2015
Band of Highest Paid Director's Total Remuneration (£000's)	185 - 190	170 - 175
Median Total Remuneration* £'s	27,840	27,306
Remuneration Ratio	6.7	6.4

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
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

Where the calculation in the Pension Related Benefits results in a negative number, a zero is substituted, this is in line with SI 2013, No 1981 - The Large and Medium sized-Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013. Negatives were previously shown in 2014/15 for Dawn Stephenson, Sean Rayner, Karen Taylor and Diane Smith, these have been restated to zero.

The Trust operates a Performance Related Pay scheme (PRP) for Directors. The scheme in 2015/16, which is non-attributable and non-pensionable and has a maximum value of 10%, provides for a maximum award of 5% for achieving all four Gateway Objectives and discretion for the Remuneration and Terms of Service Committee to award 2% where 3 out of the 4 are achieved or to award 1% where 2 out of the 4 are achieved. In 2015/16, for any performance award to be made, the Trust must receive a rating of 'good' or 'outstanding' from its Care Quality Commission inspection (undertaken in March 2016), which is part of the gateway covering effective governance, maintaining compliance and service quality. Also, 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 individual Director performance and approved by the Remuneration and Terms of Service Committee to a maximum of 5%. In 2015/16, 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 2015/16 the accounts include £83k accrual as an estimate for the award of PRP which related to 2015/16 performance. The PRP award will be proposed by the Chief Executive and will be approved by the Remuneration and Terms of Service Committee in 2016/17. This will be disclosed in detail in the remuneration report in the 2016/17 accounts.

The Annual Performance Related pay in 2015 / 2016, disclosed in the table above, relates to payments made in 2015 / 2016 for performance in 2014 / 2015 which was approved by the Remuneration and terms of service Committee in 2015 / 2016.

Other remuneration for 2015/16 relates to payment for substantive clinical posts held within the Trust.

Expenses for 2015/16 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).

* 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.

Signed……
Rob Webster Chief Executive Date 23 May 2016

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 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £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 (left 31/03/16)	60	0 - 5	260 - 265	1,272	1,223	16	0
Alan George Davis, Director of Human Resources and Workforce Development	60	0 - 5	195 - 200	1,029	987	16	0
Alexandra Farrell, Deputy Chief Executive (and Director of Finance to 31/12/15)	60	0 - 5	145 - 150	727	689	19	0
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	65	(0 - 5)	85 - 90	540	506	21	0
Adrian Berry, Medical Director	55	35 - 40	270 - 275	1,273	1,060	184	0
Dawn Stephenson, Director of Corporate Development	60	(10 - 15)	140 - 145	721	746	(45)	0
Sean Rayner, District Service Director, Barnsley and Wakefield	60	0 - 5	150 - 155	709	681	10	0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	55	0 - 5	170 - 175	818	786	11	0
Diane Smith, Director of Service Innovation and Health Intelligence	60	0 - 5	140 - 145	774	721	33	0
Carol Harris, Director of Forensic and Specialist Services (from 21/03/16)	60	0 - 5	120 - 125	536	453	71	0
Jon Cooke, Interim Director of Finance	60	(0 -5)	130 - 135	534	525	(5)	0

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform the calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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.

Signed……

Rob Webster Chief Executive Date 23 May 2016

Section 2.3 Staff report

Our workforce is our most important resource and is by far the largest area of expenditure. 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 Trust's Strategic Human Resources Framework recognises the need to develop and re-design the workforce to ensure it is fit for purpose and sustainable. The framework has three strategic work streams relating to workforce development and planning, staff engagement and wellbeing, and leadership and management development.

The make-up of our Board and staff at 31 March 2016 is outlined below. Information on average staff numbers can be found in the accounts on page 20.

	Total	Male	Female
Non-Executive Directors	7	4 (57%)	3 (43%)
Executive Directors	6	5 (83%)	1 (17%)
Other Directors	6	1 (17%)	5 (83%)
Staff	4,608	1,055 (22%)	3,572 (78%)

During 2015/16, on average, of 4,406 WTE, 3,895 staff are on permanent contracts and 511 on 'other' contracts. This compares to 4,444 WTE in 2014/15 with 4,035 staff on permanent contracts and 409 on 'other'. Changes to our workforce reflect an ongoing drive to improve efficiency, effectiveness and productivity, and arise from our transformation programme, our cost improvement programme, our contract and tendering activity, and local and national investment priorities, such as Early Intervention in Psychosis and child and adolescent mental health services.

The staff turnover rate for the Trust at 31 March 2016 was 10.8%, which is just outside the target range of 5 to 10%.

Trust Board set a target sickness absence rate of 4.4% for 2015/16; the Trust achieved a rate of 5.0%. 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 2016.

Staff in post by occupation group	2015/16 FTE	2015/16 Heads
Add professional, scientific and technical	287	330
Additional clinical services	847	1,005
Administration and clerical	821	978
Allied health professions	251	303
Estates and ancillary	284	362

Staff in post by occupation group	2015/16 FTE	2015/16 Heads
Medical and dental	149	168
Nursing and midwifery registered	1,302	1,452
Students	10	10
Total	**3,950**	**4,608**

NB it should be noted that these figures will differ from those reported on page 20 of the accounts. The above figures are at a point in time (31 March 2016) and those in the accounts represent an average over the financial year.

Equality and diversity			Staff as at 31.03.16
Age Band	Females	Males	Total
19 and Under	5	2	7
20 – 24	97	24	121
25 - 29	296	69	365
30 - 34	373	89	462
35 - 39	396	134	530
40 - 44	457	154	611
45 - 49	538	180	718
50 - 54	640	208	848
55 - 59	475	105	580
60 - 64	230	57	287
65 - 69	50	25	75
70+	15	8	23
Total:	**3,572**	**1,055**	**4,627**

Census Group	Grand Total
Asian	3.84%
Black	2.05%
Chinese or Other	0.98%
Mixed	0.96%
White	92.16%
Grand Total	**100.00%**

During 2015/16, 32 redundancies were actioned by the Trust (see below). The exit packages were made either under nationally agreed arrangements or local arrangements approved by the Remuneration and Terms of Service Committee. Information for 2014/15 is also included below.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
<£10,000	7	5	22	20	29	25
£10,001 - £25,000	8	8	1	0	9	8
£25,001 - £50,000	6	6	0	0	6	6
£50,001 - £100,000	7	8	0	0	7	8
£100,001 - £150,000	2	4	0	0	2	4
£150,001 - £200,000	2	0	0	0	2	0
Total number of exit packages by type	**32**	**31**	**23**	**20**	**55**	**51**
Total resource cost	£1,478,000	£1,593,000	£91,000	£70,000	£1,569,000	£1,663,000

The number of 'other' departures includes 23 contractual payments made to individuals in lieu of notice (20 in 2014/15).

Exit packages non-compulsory departure	Agreements/number		Total value of agreements £000	
	2015/16	2014/15	2015/16	2014/15
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	23	20	£91,000	£70,000
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**23**	**20**	**£91,000**	**£70,000**
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	0	0

In terms of exit packages, the highest paid in 2015/16 was £160,000 and the lowest was £727 with a median of £25,832. This is against a high of £131,844 and low of £494 in 2014/15.

The approach 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.

During 2015/16, the Trust has reported £1.5 million of consultancy expenditure in relation to the provision of advice and guidance outside the normal course of business. This spend is broken down into three main areas:

- external review of the productivity of Trust services;
- advice and guidance to support the Trust's transformation programme; and
- project guidance as part of the Trust's Altogether Better programme, a programme designed to create healthier communities and better quality health services.

Staff engagement

The Trust's approach to staff engagement is set out in its staff engagement strategy and has the following objectives to:

- create a model for staff engagement that provides a better alignment between what we do now, where we want to be and identifies any gaps;
- provide a clear purpose for staff engagement activity essential to a high performing organisation;
- provide a framework to promote sustainable staff engagement;
- make clear that staff engagement is everybody's business; and
- identify the key processes by which the Trust will promote staff engagement.

Staff survey

The annual national NHS staff survey, which aims to improve the working experience in the NHS, was carried out in October 2015. The survey was sent to a randomly selected sample of 850 Trust staff. The response rate was 50%, which is above average compared with similar NHS organisations.

2014		2015		Trust position
Trust	National Average	Trust	National Average	
46%	42%	50%	41%	Above average

The survey results are presented across 32 key findings.

Top 5 ranking scores

	2014		2015		Trust position
Top five ranking scores	**Trust**	**National average**	**Trust**	**National average**	
Percentage of staff suffering work related stress	42%	42%	34%	38%	Better than average
Percentage of staff believing the organisation provides equal opportunities for career progression and promotion	90%	84%	91%	89%	Better than average
Staff satisfaction with the quality of work and patient care they are able to deliver	N/A	N/A	3.97 scale summary score	3.89 scale summary score	Better than average
% of staff working extra hours	61%	71%	63%	72%	Better than average
Staff satisfaction with resourcing and support	N/A	N/A	3.42 scale summary score	3.33 scale summary score	Better than average

Bottom 5 ranking scores

	2014		2015		Trust position
Worse five ranking scores	**Trust**	**National average**	**Trust**	**National Average**	
Percentage of staff able to contribute towards improvements at work	72%	72%	71%	74%	Worse than average
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	19%	18%	19%	15%	Worse than average
Staff motivation at work	3.78 scale summary score	3.84 scale summary score	3.84 scale summary score	3.94 scale summary score	Worse than average
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.51 scale summary score	3.52 scale summary score	3.65 scale summary score 5	3.72 scale summary score	Worse than average
% reporting good communication between senior management and staff	26%	30%	28%	33%	Worse than average

Changes in the results since 2014

The Trust's results improved in the following areas.

- Percentage of staff suffering work related stress in the last twelve months 34% (2014 score 42%)
- Percentage of staff happy with the quality of work and patient care they are able to deliver 3.97 scale summary score(2014 score 3.89)
- Percentage of staff reporting errors, near misses and incidents witnessed in last month 91% (2014 score 87%)

The Trust's results have worsened in the following areas.

- Percentage of staff working extra hours 63% (2014 score 60%) (although this is 9% below the national average)
- Percentage of staff/colleagues reporting most recent experience of violence 69% (2014 score 76%)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months 30% (2014 score 28%)
- Percentage of staff reporting most recent experience of harassment, bullying or abuse 45% (2014 score 47%)

Actions 2015 NHS Staff Survey

The action plan will focus on the following key areas where the feedback from staff identified that the Trust needed to improve and where the results were below average.

Violence and harassment

The training for staff in mental health services is provided by the management of aggression and violence team whilst for community services it is through security management specialists. The incidents of aggression and violence in mental health services are monitored by the managing aggression and violence Trust-wide action group (TAG) with other incidents monitored through the Health and Safety Steering Group. A combined dashboard will be developed to present a full picture of incidents of aggression and violence across all services, whilst retaining the individual data sets for each service. The Trust continues to encourage all staff to report incidents of violence and harassment.

Communication between senior management and staff, and staff engagement

Existing internal communication channels are under review (such as the intranet and weekly staff updates) and new channels are being explored (such as, video briefings, roadshows and team briefings). Emphasis is placed on increasing two-way communications rather than top-down. A revised marketing, communications and engagement team structure has established a business partner arrangement within BDUs to help strengthen local communications and engagement. An internal campaign to disseminate Trust objectives is also planned for June 2016.

Errors, near misses and incidents

The Trust's Patient Safety Strategy aims to improve the safety culture throughout the organisation and is supported by an action plan for implementation over the next two years. The Trust has developed dashboards from its incident reporting system, DATIX, which provide real time information on incidents and training has been provided to managers and deputies to support them in navigating the system. The importance of giving feedback to staff was reinforced during this exercise.

Each serious incident has a learning lessons event open to the team involved and to share learning across BDUs. From April 2016, staff reporting incidents will be able to request feedback about the outcome of the incident, which will come from the manager's review of the incident once the incident is finally approved.

Use of patient experience information

This is currently under review by the customer experience group led by the Director of Corporate Development. Further developments to be explored for collecting feedback include the introduction of text messaging, interactive voice messaging, app-based feedback software, online surveys and options for the deaf and blind. Structures will also be established across all levels to ensure collecting patient experience and acting upon it is embedded into the organisation, ensuring 'every voice counts'.

Other local surveys/related workforce initiatives

The NHS staff survey results are reviewed alongside the Trust's wellbeing at work survey results, which has been administered in partnership with Robertson Cooper, occupational psychologists. Results from the survey in March 2015 highlighted areas of improvement around resources, communication and levels of physical health. Areas identified for development included job security and change, in particular future job change, which was the highest area of concern for staff. Also, lack of involvement in decision-making and concerns about communications around change were also raised.

In response to the feedback there has been a significant effort to improve communications and engagement across the organisation. Existing internal communication channels have

been revised, such as the Trust's intranet and the weekly staff, and new channels are being explored, such as video briefings, roadshows and team briefings. Emphasis is placed on increasing two-way communications, and staff engagement is seen as a key priority. A staff engagement strategy was approved by our Board in June 2015 and this focuses on improving levels of involvement and engagement across the organisation and how we learn from feedback from staff.

We have also invested in leadership and management development, including the Middleground 4 programme, and occupational health and wellbeing services continue to develop plans for targeted support in line with the new targets for employee wellbeing. There have also been developments at a service level to improve wellbeing, resilience and engagement including team away days, celebration events and improvements to supervision arrangements.

Review of the NHS Staff Survey action plan

The Trust has developed an action plan in response to the NHS Staff Survey 2015, which will be overseen by the Wellbeing at Work Partnership Group. The group will also monitor progress in delivery of the action plan focussing on the key areas outlined above. Progress will be reviewed by monitoring NHS Staff Survey data and other relevant workforce information.

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 2016 and any new arrangements entered into in 2015/16. The Trust's policy towards off-payroll arrangements is that it enters into them as an exception and, in instances where it does so, this reflects the need to secure specialists undertaking short-term roles for which internal capacity or expertise is not available or consultancy support and advice required outside of the normal business environment.

TABLE 1: For all off-payroll engagements as of 31 March 2016 for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2016	33
Of which:	
- number that have existed for less than one year at the time of reporting	17
- number that have existed for between one and two years at the time of reporting	10
- number that have existed for between two and three years at the time of reporting	2
- 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 individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

TABLE 2: For all new off-payroll engagements or those that reached six months in duration between 1 April 2015 and 31 March 2016 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 2015 and 31 March 2016	16
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	0
Number for whom assurance has been requested	16
Of which:	
- number for whom assurance has been received	16
- number for whom assurance has not been received	0
- number that have been terminated as a result of assurance not being received	0

TABLE 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016	
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.	22
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.	During the year, the Trust had 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 and then for a further year on 1 June 2016. The arrangement will effectively end on 31 May 2017. 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 for the Trust's, specialist services (primarily child and adolescent mental health and forensic services) and to provide capacity within the Trust's senior team. This was an interim Director-level post designed to address a number of operational issues within the child and adolescent mental health service. The individual engaged was an experienced senior manager and the engagement ended on 25 March 2016.

Rob Webster
Chief Executive
23 May 2016

Section 2.4 Foundation Trust 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. The Trust is required to provide a specific set of disclosures in its annual report to meet the requirements of the Code of Governance. For provisions in the Code that require a supporting explanation, even where we are compliant, are included in our annual report. There is also a further set of provisions that have a “comply or explain” requirement. The Trust can confirm that it complies with these provisions.

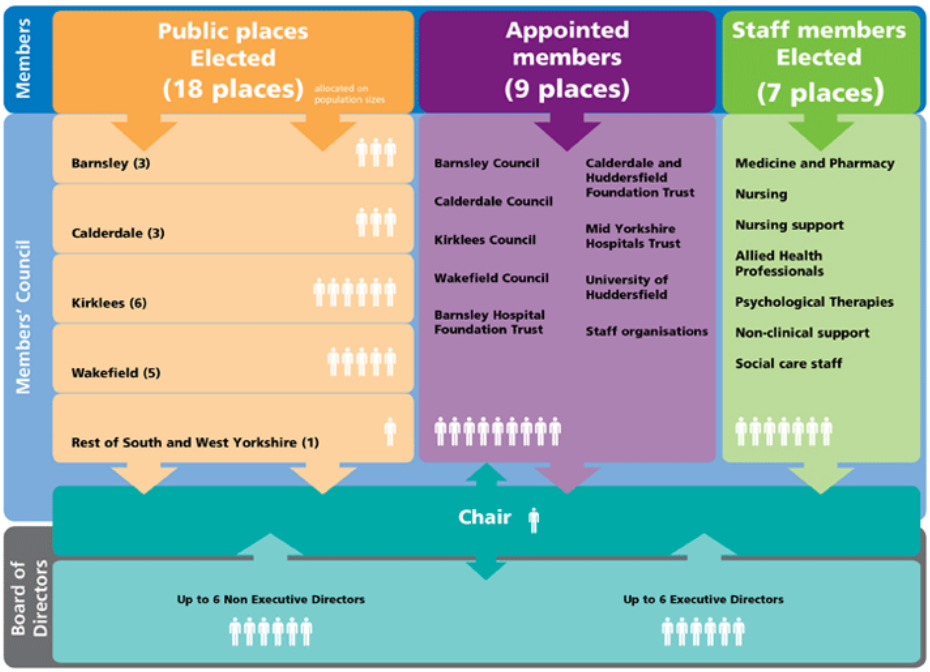
Our Members’ Council

Our 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, including appointing and removing the Chair and other Non-Executive Directors, agreeing the remuneration of the Chair and other Non-Executive Directors, ratifying the appointment of the Chief Executive, and appointing and removing the Trust’s external auditor. The Members’ Council is also presented with the annual report and accounts and the report from our external auditor, and provides views on our forward plans. It also reviews the Trust’s approach to membership and the 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 chairing due to a conflict of interest in relation to the business being discussed, be a member of Nominations Committee, 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.

Michael Smith was appointed as Lead Governor by the Members' Council in April 2015, following a recommendation from the Nominations Committee, for a period of two years, subject to his re-election as a governor in 2016, from 1 May 2015 to 30 April 2017 with the option to extend the appointment for a further year to 30 April 2018 if he was re-elected as a governor. Given the outcome of the election early in 2016, a process has begun through the Nominations Committee to appoint a new Lead Governor from the publicly elected governors on the Members' Council for approval in July 2016.

Our governors

The table below sets out the governors in place as at 31 March 2016.

Name/representing	Term of office	Attendance during 2015/16
Lead Governor		
From 1 May 2015 **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
To 30 April 2015 **WILKINSON, Tony** Elected – public Calderdale	1 May 2010 for three years Re-elected 1 May 2013 for three years	Attended four out of four meetings

Governors		
ADAMOU, Marios Elected – staff medicine and pharmacy	1 May 2012 for three years Re-elected 1 May 2015 for three years	Attended two out of four meetings
BAINES, Stephen Appointed – Calderdale Council	3 October 2014	Attended three out of four meetings
BROWNBRIDGE, Garry Elected – staff psychological therapies	1 May 2014 for three years	Attended two out of four meetings
COLLINS, Michelle Appointed – Wakefield Council	1 June 2015	Attended none out of three meetings
CRAVEN, Jackie Elected – public Wakefield	1 May 2014 for three years	Attended four out of four meetings
CROSSLEY, Andrew Elected – public Barnsley	1 May 2014 for three years	Attended four out of four meetings
DEAKIN, Adrian Elected – staff nursing	1 May 2012 for three years Re-elected 1 May 2015 for three years	Attended two out of four meetings
DURES, Emma Appointed – Barnsley Council	22 June 2015	Attended none out of four meetings
FENTON, Michael Elected – public Kirklees	1 May 2014 for three years	Attended one out of four meetings
GIRVAN, Claire Elected – staff allied health professionals	1 May 2012 for three years Re-elected 1 May 2015 for three years	Attended three out of four meetings
HASNIE, Nasim Elected – public Kirklees	1 May 2011 for three years Re-elected 1 May 2014 for three years	Attended three out of four meetings
HAWORTH, John Elected – staff non-clinical support	1 May 2012 for three years Re-elected 1 May 2015 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
HOLLINS, Chris Elected – public Wakefield	1 May 2015	Attended one out of three meetings
KIRBY, Susan Elected – public Kirklees	1 May 2015	Attended one out of three meetings
MASON, Ruth Appointed Calderdale and Huddersfield NHS Foundation Trust	8 November 2011	Attended three out of four meetings
MORTIMER, Bob Elected – public Kirklees	1 May 2009 for three years Re-elected 1 May 2012 for three years Re-elected 1 May 2015 for three years	Attended four out of four meetings
PRESTON, Jules Appointed – Mid-Yorkshire Hospitals NHS Trust	13 June 2013	Attended two out of four meetings
REDMOND, Daniel Elected – public Calderdale	1 May 2014 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 three 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 two out of four meetings

The following governors left the Members' Council during 2015/16.

Name/representing	Term of office ended/reason
ASKEW, Jean Appointed Wakefield Council	6 May 2015 Did not stand for re-election as a Councillor
BREARLEY, Hilary Appointed Barnsley Hospital NHS Foundation Trust	31 May 2015 No longer employed by Barnsley Hospital NHS Foundation Trust
DALE, Doug Elected – public Wakefield	30 April 2015 Did not stand for re-election
EDWARDS, Netty Elected – staff nursing support	30 April 2015 Did not stand for re-election
KLAASEN, Robert Elected – public Wakefield	30 April 2015 Did not stand for re-election
FLORA, Manvir Appointed staff side organisations	22 January 2016 Resigned (no longer employed by the Trust)
MORGAN, Margaret Appointed Barnsley Council	21 June 2015 Resigned
O'HALLORAN, Cath Appointed University of Huddersfield	2 February 2016 Resigned
RIGGETT, Kevan Elected – public Barnsley	30 April 2015 Did not stand for re-election
SMITH, Jeremy Elected – public Kirklees	30 April 2015 Did not stand for re-election

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 state in our annual report the expenses paid to our governors in the financial year and the sum paid in 2015/16 was £2,268.15 to eleven governors (against a total in 2014/15 of £2,101.09).

The election process for the Members' Council began in early February 2016 for the following seats:

Barnsley – one seat (currently vacant);
Calderdale – two seats (both retirement by rotation);
Kirklees – three seats (one retirement by rotation, one vacant and one where the governor has indicated that they wish to resign for personal reasons);
Wakefield – two seats (one retirement by rotation and one vacant);
nursing support (staff) – one seat (vacant);
social care staff in integrated teams – one seat (vacant).

The nominations process ended on 17 March 2016 and the following were elected unopposed.

Barnsley (one seat for election) – Shaun Adam
Wakefield (two seats for election) – Bob Clayden and Peter Walker (re-elected)

An election was held for two seats in Calderdale (five candidates) and in Kirklees for three seats (five candidates) and this closed on 28 April 2016. The following were elected.

Calderdale (two seats for election) – Trudi Enright and Phil Shire
Kirklees (three seats) – Carol Irving, Jeremy Smith and David Woodhead (re-elected)

The seat for the rest of South and West Yorkshire remains vacant.

No nominations were received for the staff seat for nursing support; however, a bi-election was subsequently held and Gemma Wilson has been duly elected unopposed. The staff seat for social care staff in integrated teams remains vacant.

There are also two vacant stakeholder seats (Barnsley Hospital NHS Foundation Trust and Kirklees Council), which will be pursued with the appropriate organisations.

Members' Council involvement and engagement

Our Trust Board continues to have regard to the views 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 Directors, 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. Members of our Board are encouraged to attend Members' Council meetings to ensure they understand the views of governors and of members.

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 and child and adolescent mental health services.

Holding non-executive directors to account for the performance of the board was a key area for governors and the discussion item in November 2015 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 again in 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 February 2016, governors were asked to re-visit the themes emerging from last year's strategic meeting and consider whether, in the current changing and challenging environment, these were still important in terms of the Trust's services or whether the Trust should take a more radical view of what is considered to be core provision. The contribution from governors has informed and contributed to development of the Trust's annual plan for 2016/17. Key themes emerging related to:

- 'staying on the pitch' and continuing to do the day job successfully and effectively;
- being an agent for change and an advocate for what will make a difference for people who use our services; and
- working effectively with our partners and being clear where we will partner and who we want to partner with.

All governors have 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.

<u>Strategy and forward plans</u>

- Development of the Trust's Quality Accounts.

- Forward plan for 2016/17 (joint meeting with Trust Board) in February 2016.
- Consulted on the transformation of Trust services.

Statutory duties
- Appointment and re-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
- 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 NHS Providers governors' 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, particularly in relation to the quality of our services.

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. The Trust's approach to membership and engagement is set out in *its Involving People, Working Together, Being in Control Strategy*, which is about working together to improve and develop our services for the benefit of everyone.

In summary, membership of the Trust means local people have a greater say in how services are provided in the communities the Trust serves, and that services take account of local needs. The Trust encourages people to take a special interest in our services using membership as an opportunity to shape the future of health care in our areas. Membership is free, with few specific requirements (subject to the legal exemptions on eligibility and the Constitution of the Trust), has a lower age limit of 11 and no upper age limit, and service users and carers are included in the public constituency. Our public constituencies reflect our geography in proportion to the population of each area and, although we aim to retain a membership of 1% of the populations we serve, the key focus is to encourage members to be engaged and involved with our Trust. As at 31 March 2016, we had 10,803 public members (11,042 in 2014/15). This is broken down as follows.

	2016	2015
Barnsley	1,713	1,720
Calderdale	1,800	1,857
Kirklees	4,366	4,505
Wakefield	2,924	2,960

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

- involvement in Care Quality Commission focus groups to drive up the quality of services through feedback;
- election of governors to our Members' Council to ensure sound governance arrangements;
- involvement in Customer Service Excellence Accreditation to help shape an enhanced patient experience;
- input to transformation work streams to shape future services to ensure they are fit for purpose; and
- involvement in service visits through the 15-steps programme to ensure a patient-centred approach to care.

This approach is supported by our vision for volunteering and we now have approximately 175 volunteers within the Trust, which equates to approximately 2,100 volunteer hours per week. 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. All volunteers recruited are automatically Trust members. The Trust achieved the Investing in Volunteering accreditation assessment early in 2016.

Our 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:

	2016	2015
Allied Health Professionals	588	609
Medicine and Pharmacy	222	202
Non-clinical support	1,133	1,096
Nursing	1,578	1,601
Nursing support	1,082	1,139
Psychological Therapies	203	197
Social care staff working in integrated teams	71	71

Section 2.5 Regulatory ratings

Our performance against Monitor's governance and financial risk ratings during 2015/16 has been good with the Trust remaining green in all four quarters reflecting our anticipated position set out in the annual plan.

	Annual plan 2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Continuity of service rating	Green	Green	Green	Green	Green
Governance rating	Green	Green	Green	Green	Green

	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

There were no formal interventions in 2015/16.

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*.

Rob Webster
Chief Executive
23 May 2016

Annual Governance Statement 2015/16

Scope of responsibility

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

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

The purpose of the system of internal control

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

Capacity to handle risk

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

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

In the Annual Governance Statement for 2014/15, we reflected on the challenge in terms of changes to Non-Executive Directors on the Board in the coming year as two experienced and long-standing Non-Executive Directors would come to the end of their terms of office during 2015. One of the key considerations for the Nominations Committee, which has devolved responsibility from the Members' Council to oversee and manage the process to

appoint the Chair and Non-Executive Directors, was to ensure effective succession planning with minimum disruption to the stability of the Board. As a result, the Committee sought to appoint two individuals with the skills and experience to ensure the Board retained the skill-set of departing Non-Executive Directors.

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

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

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

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

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

During the year, the changes initiated in 2013 to the Director structure at operational level continued to develop. The structure ensures strong and effective strategic and operational management is in place within each BDU whilst maintaining a strong local focus. Deputy directors are now in place across all Business Delivery Units (BDUs) providing operational leadership and management. This allows BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. This year also saw the embedding of arrangements at service line level to provide the leadership and management framework where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

Further improvements have been made to strengthen leadership in critical areas. Following an interim appointment at Director-level to cover child and adolescent mental health (CAMHS) and forensic services, with the support of the Remuneration and Terms of Service Committee, a permanent post was established to cover forensic and specialist services at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The risk and control framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information Governance

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

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

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

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

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

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

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

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

Annual Quality Report

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

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

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

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

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

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

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

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

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

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

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

Review of effectiveness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Rob Webster
Chief Executive
23 May 2016

South West Yorkshire Partnership
NHS Foundation Trust

Quality account | 2015-16

A year at South West Yorkshire Partnership Foundation Trust…

In a typical month we made more than

40,000 mental health, learning disability contacts

45,000 community health service contacts

Our national recognition

We're listed in HSJ Best Places to work in 2015

Our Forensics CAMHS service won the outstanding Collaborative Leadership of the Year award in 2015, regional NHS Leadership Academy awards and a team member won Mental Health Social Worker of the Year and Overall Social Worker of the Year 2015

Our memory assessment tool was shortlisted at the 2015 Advancing Healthcare awards

Creative Minds won the HSJ 'Compassionate Care' award in 2014

We were finalists in HSJ Board of the Year as well as at the Regional Leadership Recognition Awards 2015

Our Barnsley end of life care team were shortlisted on the 'Multidisciplinary Teamwork award category at the 2015 International Journal of Palliative Nursing awards

In the Friends & Family Test

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

80% of our patients in mental health services would recommend us to friends and family

Contents

Part 1:
Chief Executive and Chair's Welcome

Welcome to our Quality Account. This document highlights how we enable people to live well in the communities within which they live. It shows our quality improvements during 2015-16 and sets out the steps we continuously take to maintain safe services and improve our standards.

This has been a year of considerable adversity across the health and social care system as well as in our own organisation. There are increasing demands across all our services coupled with significant financial and workforce pressures.

This report shows that our staff have been able to improve services in many areas and deliver safe care within the finances that we have available. Their dedication and commitment is a fundamental part of the success of our organisation and we are indebted to them as we seek to thrive in tough times and tackle variation in our services.

In this context, the Trust Board remains focused on leading an organisation that is true to its values, delivering its mission and continually improving. As Chair and Chief Executive, we are ambitious for the people we serve and the staff we employ. Across Barnsley, Calderdale, Kirklees and Wakefield, we have the privilege of supporting some of the most vulnerable people in society. We do so with some of the most caring staff and always with the intention of putting people first and at the centre of their own care. This Quality Account shows that we often get this right and that we need to do more to make sure we always do - in every service and for every patient.

We rely on many other organisations in delivering the care we provide. Partnerships are central to our success and critical to our future. We are working in an ever-changing environment for the commissioning of services and local providers are also changing with austerity and service pressures. We know this rapid pace of change will continue over the coming years. It is only through working in true partnership and embracing the challenges and changes ahead that we will continue to thrive as an organisation, providing high quality, safe care for local people.

The importance of the place people live is clear in the health in our planning is very welcome. We are already active in Health and Wellbeing Boards in each of our districts. We now have the benefit of leading the sustainability and transformation plan for West Yorkshire (STP) as well as being active in the "vanguard" sites for the new care models programme. These will help strengthen partnership and accelerate steps towards supporting improvement and integration of services.

We are open, honest and transparent as an organisation and welcome external challenge. The Care Quality Commission did a full inspection of the trust in March 2016 and, at the time of writing; we are awaiting our final report. Part of their immediate feedback was that they found our staff to be, without exception, caring. It's something that we have always been confident of but it gives us immense pride to have it confirmed by fresh eyes.

When we receive our CQC report, it should accelerate the improvements we are in the process of making and bring new insights into areas that we need to focus on. This will help shape our quality improvements for the coming year. We know that there is a lot to do - this Quality Account shows how we are getting better and the areas where we must keep pushing. As a self-determining, confident organisation we will continue doing what's right for our staff, our patients and the people we serve. We will only succeed by working together and with our partners.

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: 25th May 2016

Chair:

Ian Black

Date: 25th May 2016

Chief Executive:

Rob Webster

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

Part 2.1 – Priorities for improvement

In part two of our Quality Account we will outline our planned improvement priorities for 2016-17 and provide a series of statements of assurance from the Board on mandated items, as outlined in the 'Detailed requirements for quality reports 2015-16' (www.gov.uk/monitor).

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

Central to this is the Trust's Quality Improvement Group. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Improvement Strategy. The functions of the group are: horizon scanning; interpretation and reporting of relevant national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; risk scanning; discussion, debate and planning.

The trust is a partner in the nationally sponsored project to develop an online Mental Health Quality Improvement Toolkit. The toolkit is designed to increase the capability of people working in mental health to improve the quality of services and will include case studies and improvement methodology and tools.

Our quality priorities

We have seven quality priorities that have been agreed through wide engagement with service users, staff and other stakeholders. They 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 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 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.

Each year the specific actions we will take under each of the seven quality priorities are agreed in line with learning. These are set out in our Quality Improvement Strategy which is being refreshed for 2016-17.

Each year to determine our quality priorities we consult with stakeholders, through the Quality Account Survey. This information, along with patient experience feedback, our Commissioning for Quality Improvement Scheme (CQUINS) and our annual governance report, has again been triangulated to determine our priorities for 2016-17. Against each of our quality priorities we have set ourselves measures of success. The measures are reviewed and refreshed each year to make sure we are adapting to both local and national intelligence and progressing against our aim to 'improve and be outstanding'. We anticipate that when we receive our CQC report we may need to add to our quality priorities for 2016-17.

Throughout 2015-16 we measured activity against each of our quality 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 2015-16'.

Although our quality priorities have remained consistent over the past three years, the quality initiatives we undertake against these priorities can change from year to year. This means we are not always able to directly compare our performance against each priority each year, as we are not comparing 'like for like'.

Our quality priorities – summary of performance in 2015-16

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. We have maintained a good standard of performance against the majority of the indicators. Overall we have achieved 71% of the key performance indicators we identified in 2015-16, and in a further 20% of cases we were within 10% of achieving the goal and in 9% we did

not achieve the goal. This is an overall increase in performance against achievement of priorities in 2014-15, when we achieved 63% of key performance indicators, with 20% partially met and 17% not met.

We have achieved high performance in the areas of access to services, recording care, care pathways and safety. The area of focus in 2016-17 will be care planning where we have not met our goals. We will continue to monitor areas where we have underperformed and review our processes to ensure all risks have a mitigation plan. Details of our achievements are discussed in 'Part 3 - Our Performance in 2015-16'.

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

A Clinical Governance Quality Group has been set up with cross-organisational multi-professional quality leader representation. The group will be responsible for monitoring quality assurance and improvement. Sustainability is also supported by a programme of reporting to the Trust Board regarding:

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

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 2016-17

Priority 1: Listen & Act - Service users are central to what we do				
What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
The Trust will demonstrate that we have listened and acted on patient feedback. We will implement actions to ensure our patient experience system remains fit for purpose.	1.Trust-wide mental health & learning disability Friends & Family Test (FFT) 2. Trust-wide Community services FFT 3. Child & Adolescent Mental Health Services (CAMHS) FFT Trust-wide 4. Develop volunteering strategy to support patient experience. 5. Accessible patient experience information for people with dementia.	80% 98% 75% Meet planned objectives Meet planned objectives	We will measure the percentage of people who are extremely likely/ likely to recommend the service to their friends and family. Progress against planned objectives Progress against planned objectives	Patient experience

Priority 2: Access - Timely access to services				
What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
Improve the access times for people who are referred into our services to ensure the right support from the right service at the right time.	1.Mental health access - waiting times : Early Intervention in Psychosis (EIP) and Improving Access to Psychological Therapies standards	Waiting time data (to be identified- in line with potential CQC recommendations	CQUIN / Contract performance	Safety and patient experience
	2. Community Health Services	Waiting time data (to be identified)	CQUIN / Contract performance	

Priority 3: Improve care and care planning (care, care planning and evaluation)				
What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
Improve the timeliness of assessment of need and provision of appropriate care.	1. In adult and older adults mental health services we will a. monitor the percentage of people who are assessed and allocated a cluster within 8 weeks & b. monitor frequency of reviews in line with care cluster guidance	98% 80%	CQUIN performance measures CQUIN performance measures	
	2. Improve care planning across Trust services (to include CQUIN: Monitor the quality of care plans: service users subject to the Care Programme Approach)	Meet planned objectives	Progress against planned objectives	Clinical effectiveness
	3. Increase the use of evidence-based practice – implementation of The National Institute for Health and Care Excellence (NICE) quality standards.	Meet planned objectives	Progress against planned objectives	

Priority 4: Improve record keeping and data quality				
What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
Ensure each intervention is accurately recorded in a timely manner to support effective care delivery.	1. We have identified top 10 areas of concern about clinical information. A project plan is being developed to address the issues. 2. Development of quality dashboard.	Meet planned objectives Meet planned objectives	Progress against planned objectives Progress against planned objectives	Clinical effectiveness and safety

Priority 5: Improve transfers of care by working in partnership across the care pathway				
What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
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.	1.Transitions in CAMHS services 2. Transitions between Learning Disabilities adult interface	Meet planned objectives Meet planned objectives	Progress against planned objectives Progress against planned objectives	Patient experience, clinical effectiveness and safety

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

What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
Our staff are our most valuable asset. By ensuring our staff feel valued and fit and well we know they are more likely to provide consistently excellent care.	1. Improving health and well-being of NHS staff	National CQUIN goals	CQUIN performance measures	Patient experience, clinical effectiveness and safety
	2. Staff FFT feedback- % of staff recommending trust as a place to work	80%	Quarterly scores (Q1, Q2, Q4).	
	3.Staff training Mental Capacity Act (MCA) Deprivation of Liberty standards (DoLs)	TBC	Workforce performance information against this new mandatory training programme	

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

What we will do	Quality indicator	Goal	How progress will be measured	National Quality Domain
We want to make sure the people who work with us and visit us are safe from harm.	1.Improving the physical health of patients with severe mental illness (PSMI)	To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: a) Inpatient wards b) Early Intervention Psychosis Services c) Community Mental Health Services (Patients on CPA)	CQUIN performance measures	Patient safety
	2.Suicide strategy implementation	Meet planned objectives	Progress against planned objectives	
	3.Safer staffing	Meet planned objectives	Progress against planned objectives	
	4. Mental Health Safety Thermometer (MHST)	Meet planned objectives as discussed with commissioners	CQUIN performance measures	

The measures identified in the Quality Priorities 2016-17 – (above) will be reported and monitored in the following ways throughout the year:

1. Quarterly reporting in the Quality and 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 and Quality Compliance Report.

Duty of candour

The Trust has embraced being open and has had a 'Being Open' policy in place since 2008. However, the introduction of a statutory duty of candour in November 2014 is seen as an important step towards ensuring an open, honest and transparent culture.

The requirements are captured in regulation 20 of the fundamental standards which indicates that any incident where moderate or more severe harm has been caused meets the requirement for duty of candour. In interpreting the regulation on the duty of candour, the CQC uses the definitions of openness, transparency and candour used by Robert Francis in his report:

• Openness – enabling concerns and complaints to be raised freely without fear and questions to be answered.

• Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

• Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The Trust has reviewed and updated its policy guidance, frequently asked questions and flowchart. Training has been delivered to team managers and/or deputies. The Patient Safety Support Team has benchmarked the Trust processes against other organisations and mapped the process. The team will inform managers of any incidents where the provisional level of harm is assessed as being moderate or severe harm or death. These will usually be incidents with severity of yellow, amber and red (however, it should be noted that severity and degree of harm are not the same). Once the degree of harm has been agreed, the duty of candour process is monitored and reported within the Trust incident quarterly reports.

Being open is reflected in the Trust's complaints management processes with the Customer Services function promoted as a single gateway to raise issues and give feedback via phone, text, email, on-line submission, letter or face to face contact. Staff at service level are supported to act locally on feedback and to respond in real time wherever possible. Customer Services support the resolution of issues and provide intelligence on themes arising from complaints and actions taken to promote learning across the organisation. Timescales for response are negotiated with complainants on an individual basis and many meet the internal 25 working day target. Complaints are monitored by Business Delivery Units on a weekly basis with quarterly scrutiny by Trust Board.

In 15/16 the Trust received 342 formal complaints, with the most common themes being communication, values and behaviours, patient care, access to treatment and drugs, policy and procedures and waiting times. Service issues and comments were raised informally, with the Trust

promoting a default position of putting things right as and when they happen, and learning from the experience of people who use services. 672 compliments were recorded and positive practice shared. Over 200 actions were logged with changes implemented in response to feedback, including improved processes for information sharing, communication and involvement in care.*

17 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. The Trust received feedback about 16 cases, with 13 closed with no further action required, 2 upheld and 1 partially upheld with appropriate actions implemented.

*Feedback is recorded on a live system with items moving between headings as issues are escalated / deescalated. The stated performance is consistent with the Trust's recording system as at 26 May 2016.

CQC inspection

The Trust received an inspection visit from the CQC in March 2016. At the time of writing this report we do not yet know the Trust's rating from the inspection.

The verbal feedback received at the end of the visit is outlined below:

• A positive message was received that our staff were caring without exception. We are proud of this achievement. The CQC also stressed how impressed they were with how we are responding to an extremely challenging environment while maintaining positive morale.

Notable areas of good practice:

- Community services in general. This included the commitment of staff in our Barnsley 0-19, our tele-health and care navigation service, our epilepsy service and our end of life care service.
- Mental health and specialist services. This included ADHD service, prison in-reach, community learning disability service, community CAMHS service and our older people's wards.

Areas of concern:

- Safer staffing, particularly on acute wards. The major concern here was around the pressures on our staffing complements across acute mental health services and also made reference to the fact that the demand and acuity was at high level. At the time of initial feedback the CQC will not have had an opportunity to consider our safer staffing report, evidence-based staffing tool and other information in respect of staff surveys etc.

  Monitoring of care and treatment in our rehabilitation services, particularly at Enfield Down. The concern here related to the multidisciplinary team reviews / care planning approach across our service, and the differences in practice between the two units. We will now need to look at how we can evidence the activity that takes place within the service and any additional information in respect of our monitoring approach that was not found at the time of the visit.

- Mental Health Act and Mental Capacity Act training and recording. The CQC said that they found many areas of positive practice across the Trust but it was not at a consistent level. They were concerned that the training was not mandatory and therefore the Trust might not have an accurate record of uptake. At the time of the initial feedback they would not have

had the benefit of our Code of Practice and MCA / MHA training action plan where we had identified this, including a proposal to make the training mandatory.

- Waiting lists for CAMHS and psychological therapies. We remain concerned, as they do, around waiting lists wherever they occur in our services and will be providing further information about the action we are taking both internally and with our commissioners in this respect.
- Physical health monitoring. This is an area where we struggled to understand their comments as there have been significant examples of positive work across the organisation. We will be providing them with further information to ensure that they have the best picture of our positive practice in this regard.

Part 2.2 – Statements of assurance from the board

Review of services

During 2015-16 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 111 relevant health services.

South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 111 (100%) of these services.

The income generated by the relevant health services reviewed in 2015-16 represents 100% of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2015-2016.

Participation in clinical audit

During 2015-2016 nine (9) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2015-16 South West Yorkshire Partnership NHS Foundation Trust participated in 9/9 (100%) 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 2015-2016 are as follows:

National Clinical Audits that SWYPFT participated in 2015-16	1) Prescribing Observatory for Mental Health (POMH) 13b: Prescribing for ADHD in children adolescents and adults 2) POMH 14b: Prescribing for substance misuse: Alcohol detoxification 3) POMH 15a: Prescribing valproate for bipolar disorder 4) National Chronic Obstructive Pulmonary Disease (COPD) 5) National Audit of Parkinson's disease 6) Early intervention in psychosis audit (EIP) 7) National Audit of Intermediate Care (NAIC) 8) Sentinel Stroke National Audit (SSNAP) post-acute organisational audit 9) Sentinel Stroke National Audit (SSNAP) clinical audit
National Confidential Inquiries SWYPFT was eligible to participate in 2015-16	7) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in during 2015-2016 are as follows:

National Clinical Audits that SWYPFT participated in 2015-16	1) POMH 13b: Prescribing for ADHD in children adolescents and adults 2) POMH 14b: Prescribing for substance misuse: Alcohol detoxification 3) POMH 15a: Prescribing valproate for bipolar disorder 4) National Chronic Obstructive Pulmonary Disease (COPD) 5) National Audit of Parkinson's disease 6) Early intervention in psychosis audit (EIP) 7) National Audit of Intermediate Care (NAIC) 8) Sentinel Stroke National Audit (SSNAP) post-acute organisational audit 9) Sentinel Stroke National Audit (SSNAP) clinical audit
National Confidential Inquiries SWYPFT was eligible to participate	7) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

National clinical audit programme 2015-2016

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 2015-2016, 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 does not specify a minimum number in their sampling framework criteria.

Title	Number of cases submitted	Commentary
POMH 13b: Prescribing for ADHD in children, adolescents and adults	Data collection May 2015 69 cases submitted from 2 teams Report received October 2015.	The national benchmark report has been disseminated to relevant clinicians. Lead person identified. Action plan implemented and will be monitored by the Drug & Therapeutics Sub-Committee and the Trust Clinical Governance Group. At this time there are no further plans to undertake a third national audit, although the local team are planning to undertake a local audit in 2017.
POMH 14b: Prescribing for substance misuse: Alcohol detoxification	Data collection January 2016. 7 cases submitted.	National report expected June 2016.
POMH 15a: Prescribing valproate for bipolar disorder	Data collection September 2015 100 cases submitted from 4 areas	National report received into the Trust on 17th May 2016. Report will be disseminated to clinicians and clinical leads, within 2 weeks, for action.
National Chronic Obstructive Pulmonary Disease (COPD) audit	Data collection January to April 2015. 18 cases submitted July 2015. Report received February 2016.	The national report has been disseminated to the relevant team. A lead clinician has been identified. The action plan has been developed and implemented. The quality of the service provided and patient enhanced outcomes are positive. There are plans to undertake a further national audit in quarter 4, 2016-17.
National Audit of Parkinson's disease	Data submitted October 2015. 50 PREM surveys submitted and the clinical audit data.	Both the national and the service report were received at the beginning of May 2016. The action plan is in development.
Early intervention in psychosis audit (EIP)	Data submitted December 2015. Approx. 80 cases were submitted from 4 teams and the organisational audit.	The national report has not yet been received.
National audit of intermediate care (NAIC) (re-audit)	Data submitted August 2015 for Crisis Response, Home Based and Bed based Services.	National and local reports received December 2015. On review there were inaccuracies with the local report which did not reflect the data submission therefore a new report has been completed. Action plan developed. This audit is not running in 2016-17.
Sentinel Stroke National Audit Programme (SSNAP)	Data collection commenced in June 2015 - ongoing	National organisational report and quarterly audit reports received. All except 2 key indicators are green. Early supported discharge and receipt of physiotherapy on the ward require improvement. The annual report will be due in May 2016 which will give the results for the whole patient pathway.

The reports of nine (9) national clinical audits were reviewed by the provider in 2015-2016 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) 2015-2016

Title	Number of cases submitted	Commentary
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	31 (78%)	9 questionnaires continue to be processed.

Local clinical audit

During 2015-2016 the Clinical Audit and Practice Evaluation (CAPE) pRiOritised plan had a total of 187 projects listed. The reports of 98 local clinical audits / practice evaluations were reviewed by the provider in 2015-2016. There are 57 projects in progress and 32 have either been deferred into 2016-17 or removed from the programme. 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 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was two hundred and forty three (243).

During this period the Trust was involved in conducting fifty five (55) clinical research studies in mental health, learning disabilities and community services. The involvement in large research projects that the National Institute for Health Research (NIHR) supported was thirty six (36). One hundred and eighty nine (189) members of staff participated as researchers in studies approved by an ethics committee with twenty three (23) of these in the role of Principal Investigator.

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 (decommissioned 31.3.16)
- 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.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2015-16.

South West Yorkshire Partnership NHS Foundation Trust has participated in one special review by the Care Quality Commission relating to a Review of Safeguarding and Looked After Children in Wakefield November 2015. The Trust received 3 recommendations:

- Implement a system to quality assure the level of detail provided in referrals to children's social care by the adult mental health service, including a clear articulation of the risks to the child or young person.

- Implement a system that enables staff to fully embed the 'think family' model into practice in the adult mental health service as well as the management oversight to ensure this is applied effectively.

- Formalise arrangements in the adult mental health service for providing written information to child protection conferences in lieu of attendance and for using information received from conferences to help plan their clients' care.

Following receipt of the recommendations an action plan was developed and monitored internally and by NHS Wakefield clinical commissioning group (CCG). Up to press all actions have been achieved within their specified date, with final actions having an implementation date of October 2016.

The Trust received its CQC inspection in March 2016 and we are currently awaiting the outcome.

In February 2016 the Trust received the latest CQC Intelligent Monitoring report, which is a report the CQC have developed for monitoring a range of key indicators about Trusts that provide Mental Health services. These indicators relate to the five key questions the CQC ask of all services – are they safe, effective, caring, responsive and well-led? The indicators are used to raise questions about the quality of care. Our current risk rating sits at a 4 (lowest possible risk).

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of income in 2015-16 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 2016-17 and for the following 12 month period are available electronically at www.swyt.nhs.uk

The Trust met 88% of its quality innovation goals in 15-16

An overall total of £4,522,291 was available for CQUIN to SWYPFT in 2015-16 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £2,367,976 (88%) is expected to be received for the associated payment.

By comparison 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%) has been received for the associated payment.

The following tables show our CQUIN achievement across 2015-16

Locality	Service	Goal	Expected financial value of indicator if fully achieved (£)	Percent achieved
Wakefield, Kirklees, Calderdale	Mental health and learning disabilities	MH Currencies	452,872	82%
		LD: Outcome Measures	226,090	100%
		Care Plans	452,871	55%
		CAMHS: Outcomes Based Interventions	75,612	50%
		Safety Thermometer	108,492	100%
		Access: Early Intervention for Psychosis	344,379	93%
		Improving Physical Health	353,830	47%
		Improving Urgent & Emergency Care	353,830	100%
		TOTAL	**2,367,976**	**78%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved (£)	Percent achieved
Secure services	Secure services	Improving Physical Healthcare	112,467	100%
		Active Engagement Programme	149,956	100%
		Smoking Cessation	149,956	100%
		Carer involvement	149,956	100%
		TOTAL	**562,335**	**100%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved (£)	Percent achieved
Barnsley	**Mental health, community services and learning disabilities**	Dementia & Delirium	159,198	100%
		Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)	159,198	66%
		Mental Health Clustering	254,717	72%
		Care Navigation/Tele-health	382,075	100%
		LD Cancer Screening	382,075	90%
		High Performing Teams	254,717	75%
			1,591,980	**86%**

NHS Number and General Medical Practice Code Validity

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode statistics that are included in the latest published data.

Records that included the patient's valid NHS number 2015-16:

99.9% for admitted patient care

100% for outpatient care

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

99.9% for admitted patient care

100% for outpatient care

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

98.8% for admitted patient care

100% for outpatient care

Information Governance Toolkit attainment

South West Yorkshire Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2015-16 is 66% and is graded green.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office. There have been two such incidents reported in 2015/16. The first related to a complaint received by the Trust from a solicitor acting on behalf of the mother of a child that was a previous service user in relation to an incorrectly addressed letter containing sensitive

information. Some of this information was then allegedly uploaded to social media. An investigation was initiated and a number of actions have been taken as a result including a capability review, enhanced staff training and a review of policies and procedures.

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

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

Clinical Coding accuracy

Our latest audit of clinical coding showed 99% of primary diagnoses and 100% 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 2015-16 randomly selected 100 records relating to discharges episodes of inpatient care occurring between April and October 2015; 828 recorded diagnoses and 27 procedures were audited. 99% of primary diagnoses and 100% 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. 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. There was continued focus in 2015-16 on improving the quality of clinical record keeping through key staff engagement events to identify priority areas and ensure staff understood why they were important and the launch of a data quality e-learning module. Much of the final quarter of the year was focussed on supporting staff to maintain data quality following a significant upgrade to the Trust's mental health clinical system, RiO.

South West Yorkshire Partnership NHS Trust will take the following action in 2016-17 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 Improving Clinical Information Group will oversee the development and delivery of the 2016-17 data quality improvement programme and will provide progress updates to the executive management team.
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%
		SWYPFT 2015-16	98.66%	97.98%	95.64%	97.44%	97.43%
		NHS England (NHSE) data 2015-16	97.0%	96.8%	96.9%	97.2%	97%
		NHSE provider lowest performance (2015-16)	88.9%	83.4%	50.0%	80%	50%
		NHSE provider highest performance 2015-16	100%	100%	100%	100%	100%

Our annual performance for 'patients on care programme approach who were followed up within seven days' has improved each year, and we are within the top performing organisations nationally.

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:

- An Improving Clinical Information 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 a robust process to improve the quality of their clinical data.
- Each business delivery unit is provided with performance and quality reports on a 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%
		SWYPFT 2015-16	95.81%	97.29%	96.04%	98.32%	96.81%
		NHS England (NHSE) data 2015-16	96.3%	97.0%	97.4%	98.5%	97.2%
		NHSE provider lowest performance 2015-16	18.13%	48.5%	61.9%	84.3%	18.13%
		NHSE provider highest performance 2015-16	100%	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:

- An Improving Clinical Information Group sponsored and chaired by the Director of Nursing, Clinical Governance and Safety, 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 a 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

Indicator	NHS Outcomes Framework Domain	SWYPFT data				
		2011-12	2012-13	2013-14	2014-15	2015-16 (Q1-Q4)
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%	9.7%

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

- 90.3 % 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:

- An Improving Clinical Information 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 a 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 2015

Indicator	NHS Outcomes Framework Domain	2012 (score out of 5)	2013	2014	2015	2015 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	3.59	3.66	3.70

		Ethnicity	SWYPFT 2014	SWYPFT 2015	Average (median) for combined MH/LD & community Trusts 2015
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	17%	20%	20%
		BME	36%	13%	23%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	91%	91%
		BME	70%	94%	78%

There have been a number of workforce initiatives developed during 2015/16 to reduce bullying, harassment and abuse from staff and improve equal opportunities within the organisation.

A key focus has been ensuring that the Trust continues as a values based organisation. The Trust's values include being 'Respectful' which aims to provide a positive environment for service users, carers, staff and volunteers and support the reduction in harassment and bullying. Incorporating the Trust's values into the key employment policies has been a key priority such as recruitment processes, induction and appraisal. The Trust's harassment and bullying policy has also been reviewed.

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.

<table>
<tr><th rowspan="2">Indicator</th><th rowspan="2">NHS Outcomes Framework Domain</th><th>SWYPFT 2015 Score (out of 10)</th><th colspan="2">National 2015score</th></tr>
<tr><th>Highest trust score</th><th>Lowest trust score</th></tr>
<tr><td rowspan="6">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.</td><td rowspan="6">2: Enhancing quality of life for people with long-term conditions

4: Ensuring that people have a positive experience of care</td><td>8.00</td><td>8.2</td><td>6.8</td></tr>
<tr><td rowspan="2">SWYPFT 2014 score</td><td colspan="2">National 2014 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>7.9</td><td>8.4</td><td>7.3</td></tr>
<tr><td rowspan="2">SWYPFT 2013 score</td><td colspan="2">National 2013 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>8.6</td><td>9.0</td><td>8.0</td></tr>
</table>

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 action 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 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 (%)**
15-16 Q1	1322	3	0.22%	10	0.75%
15-16 Q2	1502	8	0.53%	9	0.39%
15-16 Q3	1516	4	0.26%	12	0.79%
15-16 Q4	1598	6	0.37%	8	0.50%
Totals:	5938	21	0.35%	39	0.65%

The Trust has a comprehensive policy on the reporting and investigation of incidents; *Incident reporting and Management Procedures (including serious incidents).* The Trust's policy supports reporting in line with national reporting guidance from NHS England (Serious Incident Framework and National Reporting and Learning System). Staff are encouraged to report any *potential unexpected deaths* as incidents. Such deaths are investigated to establish the cause of death. This is followed up with the Coroner's office where necessary. Where the cause of death is not thought to be from natural causes, or where there may have been care delivery issues, further investigation is undertaken.

This data has been prepared on 6 April 2016, and it should be noted that the reporting rate to NRLS will increase.

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

- In 2015-16, the Trust uploaded a total of 5938 patient safety incidents to the NRLS, compared with 4534 reported in 2014-5's Quality Accounts. 96% of the 5938 incidents resulted in no harm or low harm.

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

- The Trust reported a total of 60 severe harm and patient safety death incidents in 2015-16, compared to 65 incidents in 2014-15.

- Although this is a reduction in the number of severe harm and patient safety death incidents, it is difficult to make comparisons in annual figures, because not all incidents reported up to 31 March 2016 will have been reviewed and uploaded to the NRLS at the date of the report.

- In relation to the total number of incidents uploaded, the percentage of severe harm incidents has remained fairly consistent at 0.35% compared with 0.30% in 14-15. The number patient safety deaths uploaded to NRLS in 15-16 has decreased to 0.66% compared with 1.10% in 14-15.

During 2015-16 the patient safety support team have established processes to ensure the provisional monthly NRLS data released by NHS England is reviewed and any areas for action taken. This includes monitoring severe harm or death related incidents, and any data quality and processing issues. This may have resulted in a decrease in patient safety related deaths that may previously have been uploaded.

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 and a trust wide Patient Safety Clinical Reference Group coordinate trust wide learning.

In March 2016, NHS Improvement published a 'Learning from Mistakes' ranking of NHS Trusts. This draws on data from the staff survey and patient safety incident reporting data submitted via NRLS to show which trusts have the best reporting culture and which ones need to be better at supporting staff who wish to raise concerns. South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is in the 'good' category, being ranked 117/230. In relation to the NRLS data used to calculate this rating, there were no concerns/flags identified.

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 and one locally selected indicator as described in the 'detailed requirements for quality report' (Monitor,2016) (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's governors were

1. ***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:

2015-16	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DTOC	**2.02%**	**1.88%**	**3.19%**	**2.33%**

Please note: Whist there was a requirement for this RAF DTOC calculation to be stated, it was not subject to external audit.

The 'Detailed guidance for external assurance on the quality reports 2015-16' 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 figures using this calculation, which have been subjected to audit, are presented below.

2015-16	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DTOC figures	2.00%	2.95%	2.54%	2.34%

2. ***Gate kept admissions***: the percentage of admissions to inpatients services that had access to Crisis Resolution/Home Treatment teams

The performance we reported to Monitor against these figures are on the table 'Performance against indicators set out in The Risk Assessment Framework (Monitor, 2015)' on the following page.

With regards to gatekeeping, the Deloitte report, 'Findings and Recommendations from the 2015/16 NHS Quality Report External Assurance Review, Final Report' states, 'Our testing revealed a small number of errors which had an immaterial impact on the reported performance, in view of this we did not extend our testing.'

3. **Local indicator** selected by the trust's members, for this process was ***care planning.***

Definition: Are all patients who are being treated under Care Programme Approach (CPA) subject to a documented care plan within 28 days of presentation. This is a local indicator and therefore there is no relevant comparator information.

The compliance rate that we declared in the Trust mental health services clinical record keeping audit – (February 2015) for this standard was 97.5%. The Trust's external auditors undertook an examination of this indicator and concluded that due to: issues with the design of the system for gathering the performance data; a lack of robust audit trail; and inconsistencies between the performance data and the underlying patient record within RiO, the auditor was unable either to validate the stated level of performance or recalculate an accurate level of performance. The Auditor provided the Trust with recommendations to improve the quality of this data which management have accepted and will look to implement throughout 2016/17.

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 2015/16					
	Threshold	Q1	Q2	Q3	Q4	Annual
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	**95%**	99.70%	99.20%	99.18%	96.90%	**98.79%**
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	**92%**	98.35%	98.78%	98.80%	98.11%	**98.56%**
Care Programme Approach (CPA) patients having formal review within 12 months	**95%**	97.92%	98.44%	98.56%	96.60%	**97.89%**
Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	**95%**	95.81%	97.29%	96.04%	98.32%	**96.81%**
Meeting commitment to serve new psychosis cases by early intervention teams	**95%**	104.60%	113.25%	102.51%	94.14%	***96.55%***
Care programme approach (CPA) patients receiving follow-up contact within seven days of discharge	**95%**	98.66%	97.98%	95.64%	97.44%	**97.43%**
Mental health data completeness: identifiers	**97%**	99.62%	99.54%	99.45%	98.43%	**99.27%**
Mental health data completeness: outcomes for patients on CPA	**50%**	77.63%	76.97%	78.58%	75.58	**77.19%**
Certification against compliance with requirements regarding access to health care for people with a learning disability	**Compliant**	Compliant	Compliant	Compliant	Compliant	**Compliant**
Data completeness: community services (R), comprising:						
referral to treatment information	**50%**	100%	100%	100%	100%	**100%**
referral information	**50%**	96.80%	96.80%	96.80%	96.80%	**96.80%**
treatment activity information	**50%**	96.80%	96.80%	96.80%	96.80%	**96.80%**
IAPT – Treatment within 6 weeks of referral	**75%**	N/A	N/A	71/62%	70.51%	**71.14%**
IAPT – Treatment within 18 weeks of referral	**95%**	N/A	N/A	99.37%	98.09%	**98.82%**
Delayed Transfers of care	**<=7.5**	2.02%	1.88%	3.19%	2.33%	**2.29%**

Key: Green: achieving goal Amber: within 10% of goal Red =more than 10% away from goal

Section 3:
Our Performance in 2015-16

In this section you'll find more information about the ***quality of our services***. In 2015-16 we set ourselves a series 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 2015-16 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 initiatives we undertake against these priorities can change from year to year. This 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 as part of our continual effort to improve the quality of our care.

Our seven quality priorities for 2015-16 are underpinned by a number of performance indicators. These include some current Key Performance Indicators (KPI) and also Commissioning for Quality and Innovation (CQUIN) goals. Note: the figures/ratings used in the Quality Account don't correlate exactly with achievement of CQUIN goals set by commissioners - this is because in some cases 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 34-36.

Our Trust provides a wide range of services across a number of communities. These services are commissioned from two separate commissioning groups, that is, the Barnsley area (B) and the Calderdale, Kirklees and Wakefield area (CKW). 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 2015 – 2016

The seven specified quality priorities for 15-16 are underpinned by a number of identified performance indicators including some current key performance measures and CQUIN goals. Note: figures/ratings used do not exactly correlate with achievement of CQUIN goals 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 goal achievement in each care group and BDU.

Quality Priority	Key Performance Indicators	Goal	Reporting Period		Q1 A	Q1 M	Q1 J	Q2 J	Q2 A	Q2 S	Q3 O	Q3 N	Q3 D	Q4 J	Q4 F	Q4 M	Year End Position @ Q4/ Month 12
Quality Priority 1: To continue to listen to our service users and carers and act on their feedback	% of people in forensic service who are extremely likely/likely to recommend the service to their friends & family	70%	Bi annually		**45%**									**45%**			
	% of people in CAMHS who are extremely likely/likely to recommend the service to their friends & family.	75%	Quarterly		**67%**			**69%**			**62%**			**70%**			
	% of people in district nursing services who are extremely likely/likely to recommend the service to their friends & family	90%	Bi annually		**97%**						**97%**						
	% of people in learning disability services who are extremely likely/likely to recommend the service to their friends & family	85%	Quarterly		**100%**			**97%**			**100%**			**100%**			
	Trust-wide: % of people who are extremely likely/likely to recommend the service to their friends & family in: - Mental health services - Community services	80%	Quarterly	MH	**77%**			**83%**			**79%**			**85%**			
		95%		Comm Serv	**98%**			**99%**			**97%**			**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		**80.1%**			**83.8%**			**85.67%**			**74.02%**			
	Improving access for people experiencing non-acute mental health problems (routine); face to face contact within 14 days of referral (B)	90%	Quarterly		**97.5%**			**95.3%**			**97.59%**			**91.84%**			
	CAMHS : measures to demonstrate improvement in access to services	5 weeks wait to first choice appointment	Qtly	Barnsley	**11 weeks**			**10 weeks**			**6 weeks**			**3 weeks**			
				Cald & Kirk	**6 weeks**			**7 weeks**			**8 weeks**			**7 weeks**			
				Wakefield	**9 weeks**			**5 weeks**			**5 weeks**			**4 weeks**			
	Access to care navigation and tele-health services (Barnsley Community Services)	Q1 establish baseline. Q2-4= 100% of new referrals into the service will be allocated a score	Quarterly														
	Implementation of Mental Health Crisis Care Concordat (mental health)	Progress report	Bi annually														
	Implementation of Single Point of Access across all mental health teams as part of transformation developments (mental health)	Progress report	Bi annually														

Quality priority 3: Continue to improve care, care planning and evaluation of care.	The number of people in mental health services (adult and older persons) who have had an assessment of their needs and been allocated a care pathway within 8 weeks (mental health CKW)	98%	Quarterly	**91.34%**	**91.5%**	**94.85%**	**94.13%**	
	Mental health currency development: Adherence to care pathway reviews (mental health)	80%	Quarterly	**67.06%**	**66.04%**	**71.09%**	**75.70%**	
	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 (mental health CKW)	Audit by SWYPFT & CCG: 80% of case notes to contain relevant evidence. Audit Q2 & Q4	Calderdale		**25%**		**55 %**	
			Kirklees		**51.1%**		**53.3%**	
			Wakefield		**60%**		**80%**	
	Increase the number of clinical audits that have actions implemented/ demonstrate outcomes (Trust-wide)	Progress report	Quarterly	**24%**	**31%**	**39%**	**59%**	
	Involve secure service users in a process of collaborative risk assessment and management (forensic services)	Progress report/ achievement of CQUIN	Quarterly	**100%**	**100%**	**100%**	**100%**	
	Measure the use of clinically relevant outcome tools across the learning disability (LD) service (Calderdale/ Kirklees and Wakefield) 2 parts to measure: A: % of service users for whom an outcome measure has been achieved and reviewed. B: % of improvement identified at discharge or review	A: Q1 = 50%: Q2= 60%; Q3= 70%; Q4=80% B: 50% of service users to achieve improvement at review or discharge.	Quarterly	**A= 75.29%** **B= 53.87%**	**A= 80.86%** **B= 59.47%**	**A = 73.97%** **B = 53.70%**	**A= 85.64%** **B= 59.88%**	
Quality priority 4: Improve clinical record keeping and data quality	Implementation of recommendations from clinical record keeping audits in the following areas: acute & community mental health services / community & wellbeing services / CAMHS/ forensic services/ learning disability services	Progress report	Quarterly					
	Monitor compliance with Mental Health Act documentation in: Acute and community mental health services Forensic services Learning disability services	Progress report	Quarterly					

Quality Priority 5: Continue to improve transfers of care by working in partnership across the care pathway	Delayed Transfers of Care (DTOC) 1. Monitor performance figures 2. Implementation of the Standard Operating Procedure Trust-wide - inpatient services	<=7.5 Progress update	Monthly Quarterly	**2.02%**	**1.88%**	**3.19%**	**2.33%**	
	Review and implement CAMHS transition protocols	Progress update	Annual					
	Improve communications with GPs: people on CPA with a diagnosis of psychosis should have an updated CPA care plan or a comprehensive discharge summary shared with GP.	Audit report	1 audit in Q2					
	Implementation of the Care Programme Approach framework in CAMHS	Progress report from Q2	Quarterly					
	Development of an Intermediate Care Service (Barnsley Community & Well Being)	Progress report from Q3	Quarterly					
Quality Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake their duties	Implementation of Trust-wide clinical supervision audit	Progress report	Bi Annually					
	Staff Friends & Family Test: percentage of scores recommending: 1. Trust as a place to work 2. For care and treatment	80%	Quarterly (Q1,2,4)	**60.4%** **72.5%**	**56%** **69%**		**66%** **80%**	
Quality priority 7: To improve the safety of our service users, carers, staff and visitors	Mental health safety thermometer (mental health)	Progress report	Quarterly					
	Implementation of the Sign up to Safety campaign.	Progress report	Quarterly					
	Forensic services: cardio metabolic assessment and treatment for patients with psychoses	90% by Q4	Quarterly					
	Learning disability: cancer screening (Barnsley services)	Achieve goals by Q4	Quarterly					

Key: Green: achieving goal Amber: within 10% of goal Red =more than 10% away from goal 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. The Trust routinely collects patient experience as a key component of our mission to embed quality. The measures we selected in 2015-16 are part of the national requirement to undertake the Friends & Family Test (FFT) and data presented is generated on the basis of the national guidelines and definitions.

What progress have we made?

We have continued to obtain feedback from people who use our services. We monitored six key performance measures in 2015-16 against this quality priority. The table on page 34-36 demonstrates the progress we have made in this area.

Key performance measures 2015-16

The Friends & Family Test measures we monitored during 2015-16 are:

- % of people in the forensic service who are extremely likely/likely to recommend the service to their friends and family
- % of people in child and adolescent mental health services (CAMHS) who are extremely likely/likely to recommend the service to their friends and family
- % of people in district nursing services who are extremely likely/likely to recommend the service to their friends and family
- % of people in learning disability services who are extremely likely/likely to recommend the service to their friends and family
- Overall Trust score for people in mental health services who are extremely likely or likely to recommend our services to their friends and family
- Overall Trust score for people in community and wellbeing services who are extremely likely or likely to recommend our services to their friends and family.

The Trust has been running the monthly Friends & Family Test (FFT) across the organisation since January 2015 in conjunction with its own surveys of staff and user satisfaction.

The FFT is a valuable feedback tool that asks if people would recommend the service and offers a range of responses from extremely likely to extremely unlikely. This is combined with free text comments which are available to providers more quickly than traditional survey methods and can lead to rapid action when required.

On average the Trust receives nearly 600 responses to the FFT every month. It has had over 8,000 feedback responses since January 2015.

Since March 2015 we have also taken a number of steps to increase accessibility, particularly for children and young people. These include redesigned electronic and paper surveys for children and young people with greater use of emoticons and a new easy read survey for people with learning disabilities or cognitive impairment. This work was recognised when we were shortlisted for the accessibility category of the annual FFT awards.

Users can now access the FTT information at Trust, BDU and team level as well as filtering data by demographic sub-categories such as BME or LGBT. The FFT is also uploaded to the Trust's business intelligence dashboard every month, including various breakdowns.

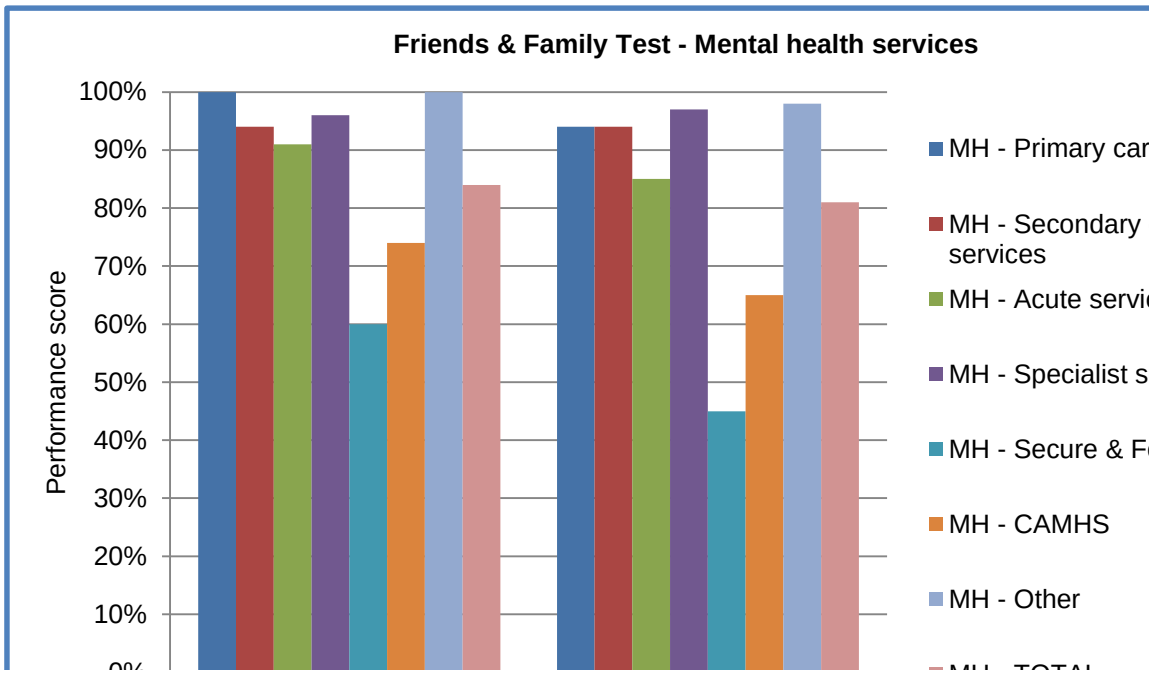
Meanwhile FFT scores are uploaded to NHS England each month while commissioners also make increasing use of the data. We provide support to low-scoring teams to improve user uptake but many others need no encouragement. In fact there are signs of a change of culture across the organisation with many teams producing their own displays of user feedback and detailing the action that resulted.

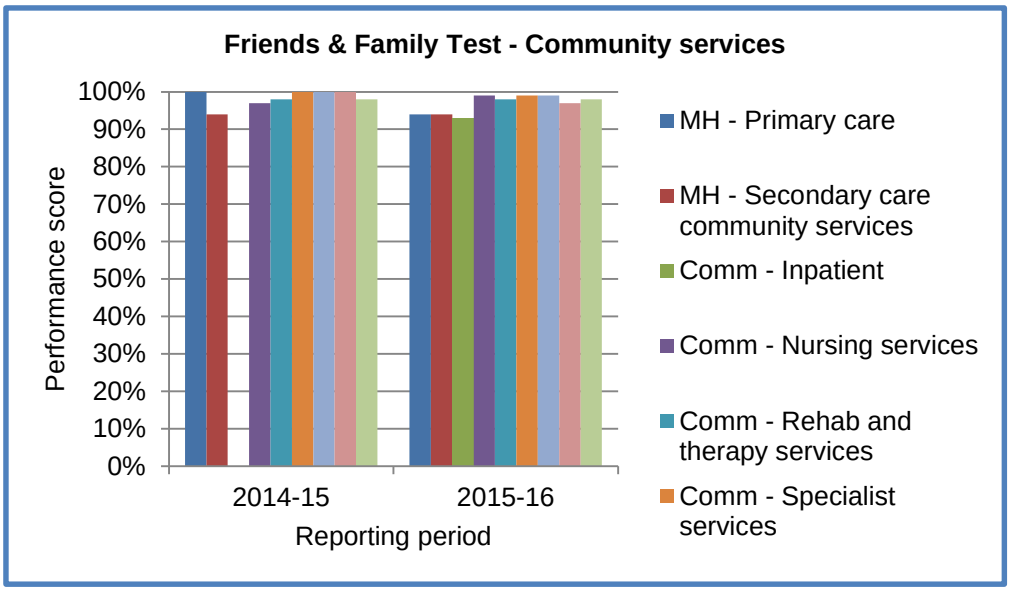
Our analysis of FFT feedback in January 2016 showed that mental health services received 357 responses from users – the most by any provider for mental health trusts in the Yorkshire and Humber areas. However, the scores were in the lower middle quartile of local providers – largely because of low scores in CAMHS. We have factored this into the service action plan.

Conversely, community health had a lower number of responses than many comparable providers in the area but at 98% its satisfaction scores were above both the local and national average.

When we analysed the reasons why users would recommend our services, one common theme that came through was the commitment and caring nature of Trust staff. The caring nature of our staff was also highlighted in the recent Care Quality Commission (CQC) inspection.

The FFT results for 2014-15 & 2015-16 show the percentage of respondents who were likely or extremely likely to recommend our services to a friend or family:





What next?

We are planning further improvements to how we operate FTT in the next year. These include:

- Introduction of text messaging and interactive voice messaging
- Improving accessibility for the deaf
- Improving feedback from CAMHS, especially the children and young people in Youth Offenders Institutes
- A range of language options for non-English speakers
- Accessible information for the FFT question for people with dementia.

We are also exploring greater use of volunteers to increase user involvement and free up clinical staff time and we are considering having 'service user experience champions' in the Forensic BDU who could take an active role in planning and conducting surveys

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 six key performance measures in relation to access to services and we achieved four of these goals. The table on page 34-36 demonstrates the progress we have made in this area.

Key performance measures 2015-16

1. **Improving access for people experiencing mental health problems by implementing a single point of access service across our adult and older persons mental health teams**

We have been operating a single point of access (SPA) as a gateway into the Trust's integrated pathways of care and have achieved most of our contractual goals in the first year of operation.

The new approach has improved patient flow and access to primary services as well as increasing the speed of access and enhancing the patient experience.

The integrated SPA team undertakes screening, triage and initial assessments of urgent and routine referrals. In Wakefield the SPA team performs screening and triage, working in partnership with Intensive Home-Based Treatment (IHBT) teams and Rapid Access for Older People who undertake urgent assessments, and all other areas of community services who undertake routine assessments. Appointments are prioritized according to need and initial contact will take place between 4 hours and 14 days of referral. All urgent referrals are assessed within 72 hours.

In Kirklees resources have been divided since November 2015 to create two key functions: a 24-hour IHBT model and a SPA covering the hours between 8pm and 8am. Calderdale has a 24-hour SPA/IHBT team. Kirklees has also developed daily multidisciplinary discussions to inform the patient flow and ensure people access the right primary care services. Calderdale has three workers linked to both the SPA and the community mental health teams (CMHTs). This ensures that referrals are managed from the point of entry through assessment and on to allocation within the CMHT where required.

The charts overleaf show our performance against both 4 hours access (urgent) and 14 days (routine) access goals in mental health services. Definitions for these goals have been agreed with our clinical commissioning group. Data is generated internally and performance is monitored as part of our contract agreement.

Table: 4 hour access – quarterly figures

BDU	Quality account goal	Trust goal	Q1	Q2	Q3	Q4
Barnsley (Adult & OPS)	Not applicable	95%	97.50%	98.50%	98.8%	99.2%
Kirklees (Adult & OPS)	Not applicable	90%	99.19%	98.15%	93.30%	92.8%
Calderdale Adult & OPS)	Not applicable	90%	96.45%	99.19%	94.90%	94%
Wakefield						
Adult	Not applicable	90%	96.10%	90.91%	83.2%	93.69%
OPS	Not applicable					

Table: 14 day access – quarterly figures

BDU	Quality account goal	Trust goal	Q1	Q2	Q3	Q4
Barnsley (Adult & OPS)	90%	80%	97.5%	95.3%	95.6%	91.8%
Kirklees (Adult & OPS)	90%	80%	76.91%	83.22%	82.60%	54.90%
Calderdale Adult & OPS)	90%	80%	82.61%	87.58%	83.60%	72.40%
Wakefield						
Adult	90%	80%	92.91%	90.77%	89.2%	77.9%
OPS		80%	75.66%	97.59%	97.7%	99.3%

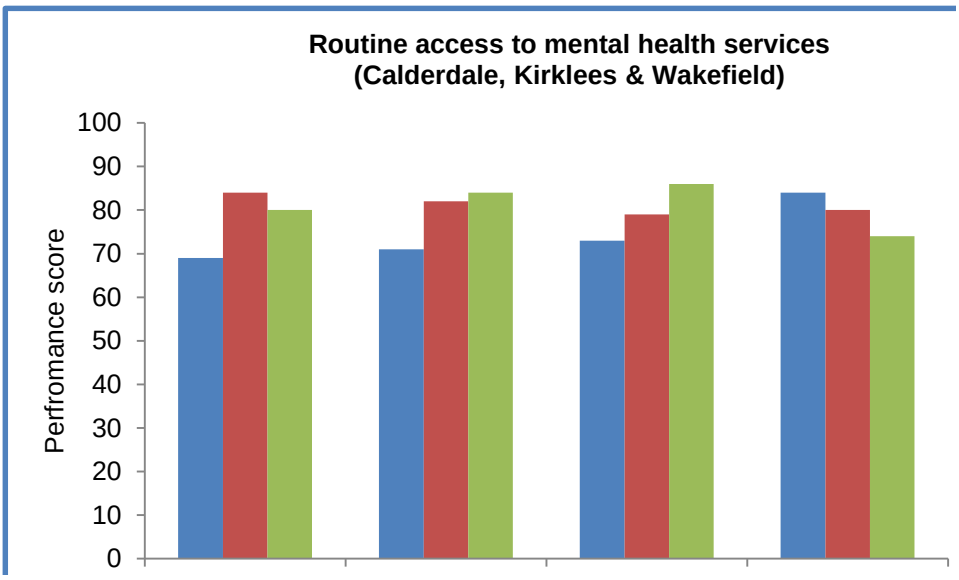
In our collective calculations for Calderdale, Kirklees and Wakefield services the performance has fluctuated throughout the year and at the end of the year performance was below the quality account goal. In our Barnsley services, the goal was achieved.

Our performance data shows that Calderdale and Kirklees met their contractual goals for both crisis and routine referrals in the first three quarters of 2015-16 with one exception – Kirklees slipped below its 80% goal for 14-day referrals in the first quarter.

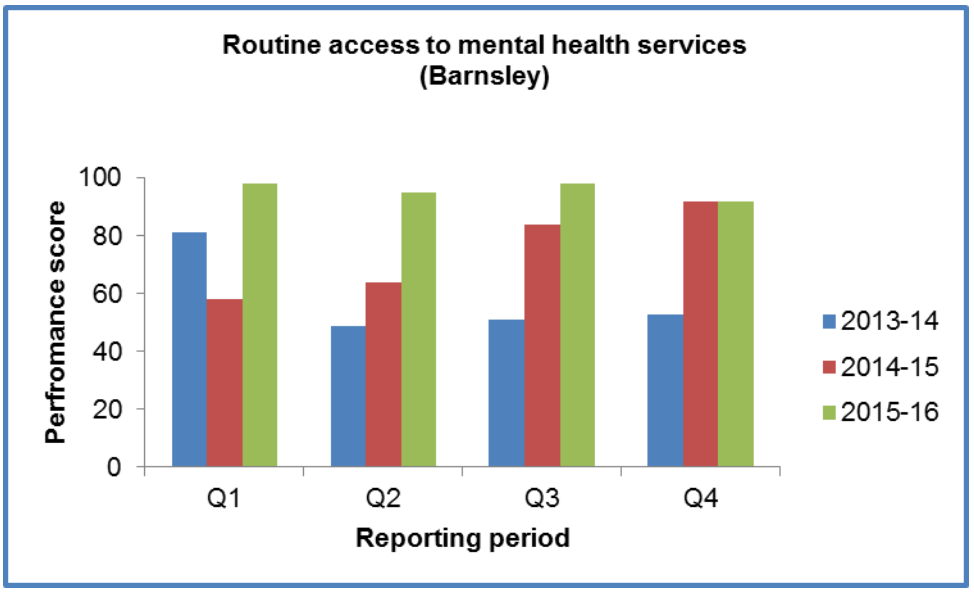
In quarter four the aggregated score for Calderdale, Kirklees and Wakefield for 14 day referrals for was 74.02%. Wakefield maintained their performance of achieving 80%; however Calderdale and Kirklees did not. Both Calderdale and Kirklees have seen a large rise in the referral rate to SPA over the last three months. As a consequence SPA clinicians have not been able to triage referrals within the usual time frame, and this delay has reduced the time in which service users can be offered an assessment. To help manage this Calderdale and Kirklees SPA have increased the amount of assessments offered. Despite this there are a high number of people who have not attended for initial assessments and have not notified us in time to reallocate these appointments to other

people. In order to address these issues within both districts SPA referrals are discussed in a daily SPA multi-disciplinary team meeting to ensure that service users are triaged into the most appropriate service to meet their needs. Additional work includes setting goals for assessments with the SPA clinicians and improving quality of the initial referral.

The charts below compare the 14 day access goal over the past three years.



Over the past three years Calderdale, Kirklees and Wakefield have steadily improved their performance in quarters 1, 2, and 3, against a backdrop of an increasing number of people being referred to services. The service managers continue to monitor the demand on the service and respond accordingly in order to achieve this goal.



As the chart above shows, performance against this measure has improved in Barnsley since the introduction of a SPA in December 2014. Barnsley's lower than usual figure for 14-day access in quarter 4 is explained by people that haven't gone through the SPA being assessed by CMHTs. Post transformation, the aim is to have a fully resourced SPA and to eliminate referrals circumventing this pathway.

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 offering a specialised service for severe, complex and persistent disorders. Team members include psychiatrists, psychotherapists and occupational therapists.

During 2015-16 we measured the number of weeks individuals waited for a first appointment to the service to check whether they were seen within five weeks. This measure has been defined by the Trust and data generated internally. Overall we achieved this goal.

Although we monitored this measure across our CAMHS teams the area that required urgent attention was our Barnsley CAMHS services, because in March 2015 the access time to their services was approximately 14 weeks. Our initial action in this service was to undertake an analysis of demand trends and we then implemented a revised clinic structure. This ensured clinical capacity was aligned and increased to guarantee 20 initial assessment appointments per week. At the end of March 2016 the wait for initial assessment has been reduced to less than five weeks. The work in Barnsley followed an equivalent process in Calderdale and Kirklees – where waits to initial assessment are now consistently within the five week standard. In Wakefield some temporary staffing issues reduced service capacity in delivering initial assessments and undermined achievement of the standard through quarters 3 and 4. These difficulties have now been corrected through a successful recruitment programme and we are confident performance in 2016-17 will return to previous levels.

3. Access to care navigation and tele-health services (Barnsley Community Services)

There is strong evidence that self-directed care is likely to lead to healthier behaviour and better clinical outcomes. With this in mind Barnsley Community Services have been working to assign patients with a long-term condition a self-resilience score that measures how ready they are for self-care.
We chose this measure from the local CQUIN scheme. The information available is generated internally and on the basis of the locally agreed objectives. The CQUIN goal was to choose a suitable tool and ensure that 100% of those referred to the care navigation and tele-health services in quarters 2, 3 and 4 received a self-resilience score – apart from those not considered suitable.

We began by choosing the Patient Activation Measure (PAM) tool to measure patients' self-resilience and then delivered training to staff within COPD, heart failure, community matron and care navigation services (CNS). PAM measures four levels of patient activation.

Our IT system, Systm 1, was also configured to include the PAM score as part of the assessment process.

In the second quarter of the year 325 patients were referred to our services of whom 209 had the minimum of one PAM tool assessment score or level. In the third quarter 220 of 338 patients had one or more PAM scores and in the fourth quarter the figure was 200 out of 314 patients.

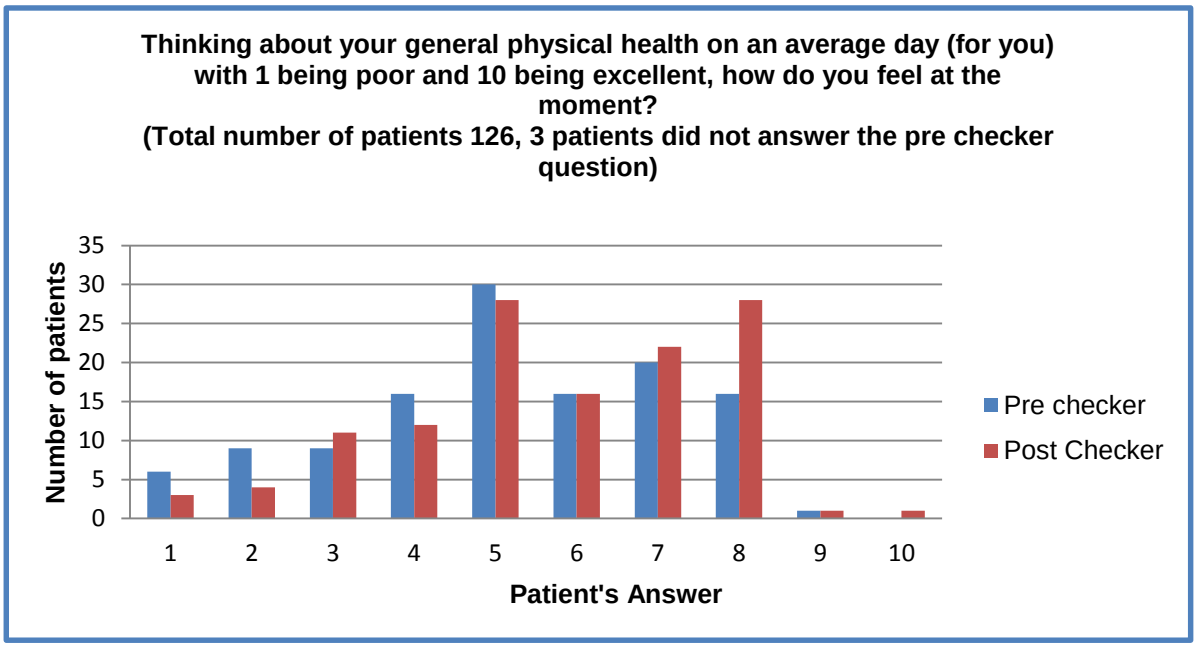
Most of those who did not register a score either declined to participate or were unable to because of factors such as mental capacity, a terminal condition or early discharge. In addition 31 patients in the third quarter had initial contact by phone rather than face to face so were not suitable for full assessment. From quarter four onwards all phone contact for new patients within the respective services required a PAM score to be completed.

Taking these factors into account, we were able to ensure that 100% of those who met all the criteria received a self-resilience score and were referred to the appropriate service.

Our user feedback surveys have been extremely positive. Most of those who responded felt they were better able to manage their condition, had all the support they needed and said their quality of life had improved since accessing the CNS. Meanwhile the number reporting low scores on their self-assessment score decreased while the number reporting high scores increased (see chart overleaf).

In addition four out of five patients said their physical and mental heath had improved since being with the care navigation services and they were now less reliant on emergency services, their GP or a practice nurse. Between two thirds and three quarters said they would not have been able to achieve this without the service.

Patient feedback from the Barnsley Health Checker holistic assessment tool 2015-16 is shown on the chart overleaf:



The results show a 10% decrease in low scores of 1-5 and an 18% increase in higher scores (6-10) among those using the Barnsley Care Navigation/ Tele-health Service.

4. Implementation of Mental Health Crisis Care Concordat (mental health)

As a Trust we are signatories to a local Mental Health Crisis Care Concordat aimed at ensuring a variety of local organisations work together to provide a high quality response when people with mental health problems urgently need help.

Calderdale and Kirklees BDU

As part of the concordat Calderdale and Kirklees BDU has been involved in two initiatives designed to improve access to mental health services and provide an early response when there is a crisis.

- *24/7 intensive home-based treatment (IHBT)*

Kirklees reorganised its services and shifted resources to enable its IHBT team to become the sole providers of 24/7 cover. A similar service is operating in Calderdale, temporarily funded by the Trust while the CCG reviews the BDU's business case.

Both teams will also have a new psychologist post. As a result the two IHBTs now undertake all four-hour assessments and act as gatekeeper for all admissions to inpatient wards at all times of the day, seven days a week.

- *Police liaison*

Calderdale and Kirklees each have two police liaison staff who are managed through the IHBTs although still embedded with the local police. Initially this scheme operated as a pilot with temporary

funding. However permanent funding has now been secured for staff across Calderdale and Kirklees.

Barnsley and Wakefield BDUs

Both BDUs have signed up to local Mental Health Crisis Care Concordats, managed by the local CCGs and bringing together a range of partners to work to common goals. A set of action plans have now been drawn up to tackle the following issues:

- Commissioning to allow early intervention and responsive crisis services
- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/ preventing future crisis.

What next?

In 2016-17 we will continue to drive improvements to access for people across our services. Our transformation programmes will be critical to ensuring that this happens. We will align this work with any recommendations that are made in the pending CQC inspection report.

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

Why did we focus on this?

We believe that individualised personal care is essential to 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 2015-16 we monitored six key performance measures against the care and care planning quality priority, and this is discussed below. The table on page 34-36 demonstrates the progress we have made in this area.

Key performance measures 2015-16

1. **People with a mental health need who have had an assessment of their need and been allocated a care pathway within eight weeks**

Undertaking an assessment and assigning someone a cluster and care package helps to ensure they will receive the correct care and treatment.

For this reason we attach importance to the requirement that 98% of patients should have their needs assessed and care needs met within eight weeks of referral. This measure was agreed as a Trust CQUIN. The data for this measure is generated internally against the CQUIN definition.

With this in mind, the new version of RiO highlights on the front page of the service user's record where a cluster is missing so staff are able to address this as soon as possible.

Unfortunately we have failed to meet this demanding goal in 2015-16. However, we would note that the margins by which the standard was missed were small in Wakefield and that the numbers meeting the goal in Calderdale and Kirklees have increased significantly over the year:

Wakefield	***Met***	***Not met***	***Calderdale & Kirklees***	***Met***	***Not met***
Q1	*95.95% (688)*	*4.04% (29)*	*Q1*	*88.94% (1,102)*	*11.06% (137)*
Q2	*95.24% (760)*	*4.76% (38)*	*Q2*	*88.50% (1,124)*	*11.50% (146)*
Q3	*94.52% (655)*	*5.48% (38)*	*Q3*	*91.94% (810)*	*8.06% (71)*
Q4	*96.78% (603)*	*3.22% (20)*	*Q4*	*95.59% (1,171)*	*4.41% (54)*

We have introduced monthly reporting within each team as a means to improve performance. Mental health community team (MHCT) reviewers will also continue to identify those occasions when a service user misses a cluster and then work with teams and individuals to try to resolve this.

2. Mental health currency development: Adherence to care pathway reviews (mental health)

Timely care pathway reviews help to ensure that the individual receives the right care and treatment. We were therefore keen to sign up to this standard, agreed as a Trust CQUIN, which measures the extent to which service users were being reviewed within the cluster frequency. The data for this measure is generated internally against the CQUIN definition.

The goal was to ensure 80% of users were reviewed in the time limit in the first half of the year, rising to 85% in the second half of the year.

We introduced a new version of RiO which highlights on the front page of the service user's record when a cluster review is due. Individual practitioners and teams can check their caseloads on RiO and be alerted to when reviews are due. In addition a BDU, service and team level report goes to service lines and team managers showing all reviews due in the next three months.

The 2015-16 data shows that Calderdale and Kirklees failed to meet their goals while Wakefield met its goal in the final quarter. It should be noted that the rates for both BDUs improved significantly over the course of the year.

Wakefield	Reviewed within frequency	No reviewed within frequency	Calderdale & Kirklees	Reviewed within frequency	No reviewed within frequency
Q1	74.69% (785)	25.31% (266)	Q1	63.67% (1,204)	36.33% (687)
Q2	79.10% (927)	20.90% (245)	Q2	60.41% (1.474)	39.59% (966)
Q3	76.79% (857)	23.21% (259)	Q3	70.88% (1,059)	29.12% (435)
Q4	81.86% (889)	18.14% (197)	Q4	73.57% (1353)	26.43% (486)

One reason for missing some of our frequency goals seems to be that services have taken time to acclimatise to the new process of reviewing clusters within the individual cluster frequency as opposed to annually, in line with the Care Programme Approach (CPA). Recent developments suggest the new system is now better understood and many areas are improving. This will be helped by the new alignment between CPA reviews and cluster frequency.

The standard will be rolled over into a new CQUIN in 2016-17. Goal-directed work will continue to help teams and individuals improve their performance and this work will be supported by the MHCT reviewers.

3. Monitor the quality of care plans: service users subject to the CPA will have a care plan that is individualised, underpinned by recovery principles and focused on staying well (mental health CKW)

This new CQUIN aims to improve the quality of care plans and in the process engage more effectively with service users and enhance their quality of life.

Under the new measure care plans have to meet five standards, which include evidence of co-production, person-centredness and having a comprehensive plan for staying well.

The extent to which the Trust achieves these standards is being tested by an audit of 100 service users on the CPA who have been in care for at least 100 days. The audit took place at the end of the second and fourth quarters of the year in Calderdale, Kirklees and Wakefield.

Prior to the first audit, teams in both BDUs were told about ways of displaying the standards and discussed how to achieve them. In addition Wakefield developed a framework to support co-production in acute services and ward teams have been reviewing the impact of this.

However, in the first audit none of the BDUs managed to meet the goal of 80% of all care plans complying with all five standards. In the audit in the second quarter a total of 49 care plans fulfilled all standards while 51 met only some of the standards.

Since then both BDUs have made changes to improve the quality of their care plans. In addition, the CCG commissioners have agreed to reduce the five standards to three.

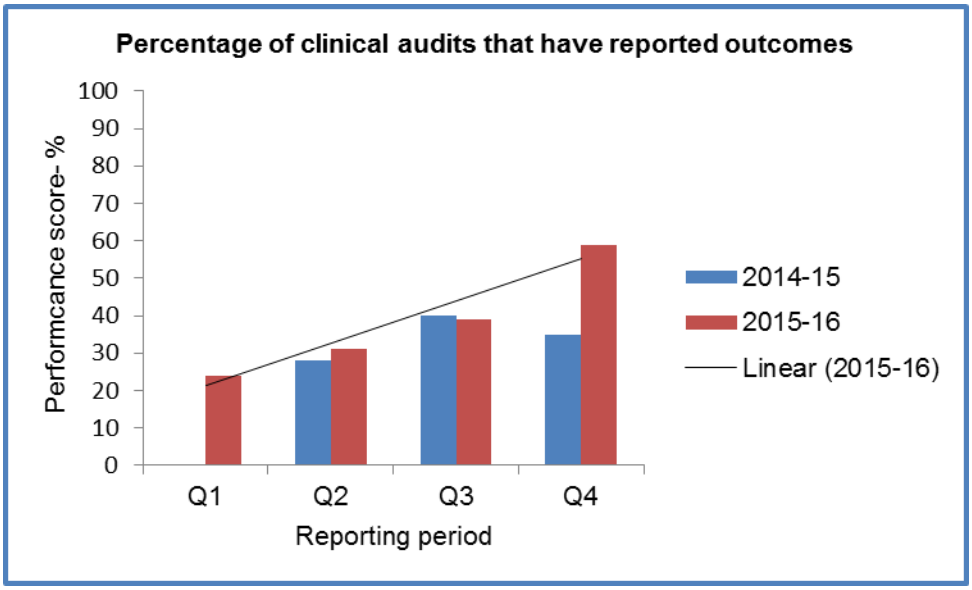
Under the terms of the CQUIN, 80% of CPA care plans should have met all the new standards by the time of the second audit. The quality of care planning has improved significantly in the meantime and this is apparent in the audit. Wakefield, for instance, achieved the new goal with 28 out of 35 users (80%) meeting all the care plan standards. However, Calderdale (55%) and Kirklees (53%) were still short of the goal.
We plan further work in partnership with the commissioners around this CQUIN for 2016-17.

4. Increase the number of clinical audits that have actions implemented/ demonstrate outcomes (Trust-wide)

The purpose of clinical audit is to improve the quality of care being provided. It is at the heart of making the necessary changes in practice that ensure the Trust is delivering efficient, person-focused, high quality care and treatment.

In 2015 our internal auditors conducted a high level review of our clinical audit processes which gave us a top rating of 'significant assurance' – meaning the system is well designed and only requires minor, low priority improvements.

Over the last year our clinical audit team has been working to ensure that all actions highlighted by the audit are implemented. Clinical teams who have undertaken a clinical audit are contacted six months after the audit and asked to report on the outcomes. This has been monitored throughout 2015-16 through the quality improvement and assurance system for monitoring outcomes. In addition a list of audits that require outcomes is taken to the Clinical Governance Group.



It is encouraging to note that the number of reported outcomes has increased consistently quarter by quarter and shows a 35% improvement from the start to the end of the process.
Clinical audits will continue to be monitored in 2016-17 as part of the Trust's ongoing quality improvement initiatives.

5. Involve secure service users in a process of collaborative risk assessment and management (forensic services)

Over the last year our forensic services have been helping service users to assess and manage their risky behaviour in collaboration with staff. We have also evaluated how this process is working and how it can be improved.

Collaborative risk assessment is based on recognition that clients should be encouraged to take responsibility for their mental health and their risky behaviour. Learning to manage risk and regain independence are among the keys to recovery.

We developed an education and training programme last year for staff and users and are now embedding the risk assessment process into clinical care through the CPA.

The service user works with a trusted member of staff to assess and review their level of risk. The aim is to generate treatment goals which are then discussed with the wider CPA meeting. Areas of agreement and disagreement are recorded as well as reasons for not participating.

The service has also produced guidance notes to help staff undertake the core element of the risk assessment process – the 5Ws. These are: What is the problem? Why me? Why now? What is keeping the risk going? What helps?

There have been encouraging signs of success. We hit our CQUIN goal of offering shared risk assessment to 50% of service users by the end of the second quarter and were able to offer it to everyone by the end of the fourth quarter.

Meanwhile an evaluation of the training and assessment process has been undertaken, with 16 service users and 33 staff members responding to the education audit and 56 service users and 67 staff giving their thoughts on risk assessment.

One conclusion from this evaluation is that it may be best to offer service users risk assessment training on a one-to-one basis. Training for groups of staff, on the other hand, seems a helpful way of increasing knowledge and generating discussion.

However, it is likely that new and unwell users would find the assessment process too demanding.

We will continue to include shared risk assessment in the CPA. And we will use the 5Ws assessments to help inform clinical teams when they consider granting a service user more independence. We will also continue to deliver training to staff and embed this in induction and core training sessions. We need to think about including shared risk assessment in staff appraisals and to consider putting the 5Ws form onto the electronic case record.

6. **Measure the use of clinically relevant outcome tools across the learning disability service (Calderdale/ Kirklees and Wakefield)**

There are two elements to this measure:

A: % of service users for whom an outcome measure has been achieved and reviewed.
B: % of improvement identified at discharge or review.

Learning disability services in Calderdale, Kirklees and Wakefield have been measuring their clients' clinical outcomes through a range of tools tailored to their individual needs.

The CQUIN initiative is an extension of the 2014-15 indicators which monitored individuals' progress against one particular tool, the Therapy Outcomes Measurement Scale (TOMS).

It was agreed the following tools would be used during the year:

- Health Equality Framework (HEF)
- Health of the Nation Outcome Score for Learning Disability (HONOS LD)
- Psychotherapy Outcome Scale – PTOS
- TOMS
- HEF and Behavioural Problems Inventory

In addition some staff also used the CORE-LD, a recent learning disability specific evolution of the CORE-OM (a mainstream MH measure).

We were set two goals. The first was to increase the percentage of those using these measurement tools from 50% in the first quarter to 80% in the last. This has been achieved with an average uptake of closer to 85% by the end of quarter 4. The data to support this measure was internally generated on the basis of the CQUIN definition.

The second goal was to ensure that 50% of those monitored showed clinical improvement either on review or discharge. This has also been achieved throughout the year.

It should be noted there were a high number of exception reports in each quarter due to the number of assessment cases and to service users not completing their treatment.

Some clinicians also pointed out that for some users with degenerative conditions it was unrealistic to expect them to show clinical improvements. In these cases no change or even a slight deterioration could be seen as a measure of success. We were advised to categorise such cases as an improvement and to provide a supporting narrative. Some outcome measurements were more accommodating of this approach than others.

We will be seeking to maintain the 80% goal for use of clinical measurement tools in 2016-17. Bringing Barnsley into alignment with the other BDUs will also help overall consistency.

What next?

In adult and older adults mental health services we will continue to monitor the percentage of people who are assessed and allocated a cluster within eight weeks and the frequency of reviews in line with care cluster guidance.

We will improve care planning across Trust services. A project will be commissioned to address the quality of care plans which will align to the CQUIN to monitor the quality of care plans and include using NICE quality standards and guidance to underpin care planning.

Priority 4: Improve record 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 offering assurance to our regulators and commissioning groups on the quality of our services.

What progress have we made?

We monitored two key performance measures against this quality priority. The table on pages 34-36 demonstrates the progress we have made in this area.

Key Performance Measures 2015-16

1. **Implementation of recommendations from clinical record keeping audits**

Our Trust-wide annual audit of record keeping identified some areas that needed improvement and over the past year we have been addressing these issues.

A. Calderdale and Kirklees

Our priorities have been to improve the quality and offer of assessments and care plans by working more closely with service users. This involves timely reviews of care and embedding the recovery approach principles to improve outcomes.

We are also using the key dates report during caseload management supervision to identify any shortfalls in record keeping around assessments and care planning. We have repeated our audit against some of the standards in one team where further action plans were called for. In addition we have produced and circulated guidance on qualitative care plans.

B. Wakefield

Wakefield has developed clinical record keeping action plans for every service line in the BDU – acute, older people and community.

We jointly developed care plan standards for people on the Care Programme Approach (CPA) who have been with the service for 100 days or more, and distributed this to all teams.
We also developed frameworks to support co-production in working age adult acute services and commissioned risk assessment training. We have undertaken audits of care plans and risk assessment and supported teams in managing the various challenges posed by the RiO IT system. We have also audited, and seen improvements in, care plan quality standards.

C. Barnsley

Community & Well Being Services

i. Children services (0-19)

The service has redesigned its record keeping audit to meet service needs. We now have a clinical lead responsible for electronic records and advice and guidance on the use of Systm One/ Child Health. We have also developed an in-house dashboard and exception reporting.

Over the past year we have demonstrated improvements in our service key performance indicators (KPIs) and contemporaneous record keeping standards. We have developed pathways and introduced guidance notes to improve the quality of record keeping and performance measures. We hold regular training sessions on clinical assessment and record keeping.

Both clients and staff reported improved service delivery after we moved the entire service to the Agile IT system which gives access to a client's records at the point of contact.

ii. Community inpatients

The audit of record keeping on inpatient services was completed in January 2015 and a re-audit is planned for 2016-17. The overall compliance rate was 95% and all action plans have now been completed. Among other initiatives we have developed a communication file with clear guidance to ensure staff are able to record phone messages and ensure relevant information is retained.

iii. Community adult services

Record keeping audits were performed across all community services in September 2015 and individual action plans devised based on the results.

Mental health

i. MH acute

The annual audit identified slight deficits in record keeping on patient demographics, assessment and use of charts.

Systems are now in place to check that patient demographic records are completed every week while the month's admissions are reviewed by the general manager and each ward manager. We have also developed an audit tool that includes nursing interventions, validation of records and

reporting and reviewing observation levels. The nurse consultant has completed an audit of levels of assessment.

We are planning further detailed audit tools for both record keeping and the use of charts. And we have developed a training package to ensure nurses are suitably trained and competent in clinical record keeping.

ii. MH community

Individual teams have developed their own action plans to ensure good record keeping. Issues such as missing information were discussed in team meetings and then monitored through the supervision process. Staff were also reminded about the need to provide printed information to service users – such as details about the service or team as well as specific disorders.

Clinical leads in the community teams have undertaken one-to-one work, with all staff using the benchmark developmental approach. We have developed individual action plans with staff to improve record keeping and encourage the recovery approach in care delivery.

iii. MH older people

The team has produced a new document for screening for falls on admission and for osteoporosis and fracture risk. We have also joined the Sign up to Safety campaign, which includes a section on preventing falls, and will be holding a Falls and Bone Health summit later this year.

D. Learning disability services

The record keeping audit was undertaken late in 2015-16. As a result the report is still pending at the time of writing.

E. Forensic services

The Forensic BDU has moved away from manual records and now has its care plans on the RiO system.
All service users have a care plan for their physical health which is embedded into their broader care.
Medical case notes have been reviewed and are now standardised across all pathways in Newton Lodge.
Clinical records on ward areas which cannot yet be accessed on RiO have been standardised and have a consistent index across all wards in Newton Lodge.
A person centred folder has been developed for all service users on learning disability wards to improve accessibility of information and easy read formats / pictorial documents.
We are in the process of reviewing the risk assessment management plan (RAMP) document used in the Bretton Centre. The Bretton Centre is also moving towards developing core care plans on RiO. These were previously in the RAMP document.
The BDU's RIO Reference Group is currently monitoring the development of a range of new documents on the RiO system. This will enable it to reduce further the manual recording of documents.

We will continue our work on digitising documents in 2016-17. We plan to record medical case notes on the RiO case note monitoring system. Improvements will be made in co-production of care plans. We will continue to develop easy read formats and to explore how we make full use of the RiO System and document management facilities.

2. Monitor compliance with Mental Health Act documentation in:

- **Acute and community mental health services**
- **Forensic services**
- **Learning Disability services**

The Mental Health Act 1983 (MHA) is the legal framework that allows mental health patients to be detained and treated against their wishes or cared for in the community under community treatment orders or guardianship. Staff who work with people who are liable to be detained have a personal responsibility to learn about the MHA and elements of the Code of Practice that are relevant to their jobs.

We undertook four clinical audits in 2015-16 to monitor our compliance with MHA documentation in acute and community mental health services. The audit tools were agreed by our Mental Health Act Committee and data for this report has been derived from the Clinical Audit reports presented to the committee.

A. Seclusion toolkit

A revised seclusion policy was introduced and implemented on inpatient wards during November 2015. The policy included a toolkit to assist staff in recording required information about seclusion incidents. In January 2016 we conducted a Trust-wide audit to determine how well we were complying with the toolkit.

The following table highlights the results from the main areas of the audit:

Section of toolkit	Calderdale	Kirklees	Wakefield	Forensic	Barnsley	Learning Disabilities	Trust
Decision to seclude	88%	94%	88%	90%	89%	29%	88%
Medical review	37%	96%	89%	73%	97%	93%	78%
Seclusion care plan	86%	92%	76%	74%	88%	10%	79%
Two hour nursing review	94%	75%	91%	81%	73%	88%	80%
Internal MDT review	17%	56%	16%	44%	71%	89%	43%
Independent MDT review	-	89%	42%	89%	53%	0%	68%
Seclusion evaluation	91%	73%	91%	90%	96%	-	89%
Report on use of seclusion	67%	75%	93%	84%	68%	-	77%

In general most BDUs are complying but this does not apply to all aspects of the toolkit or to all BDUs.

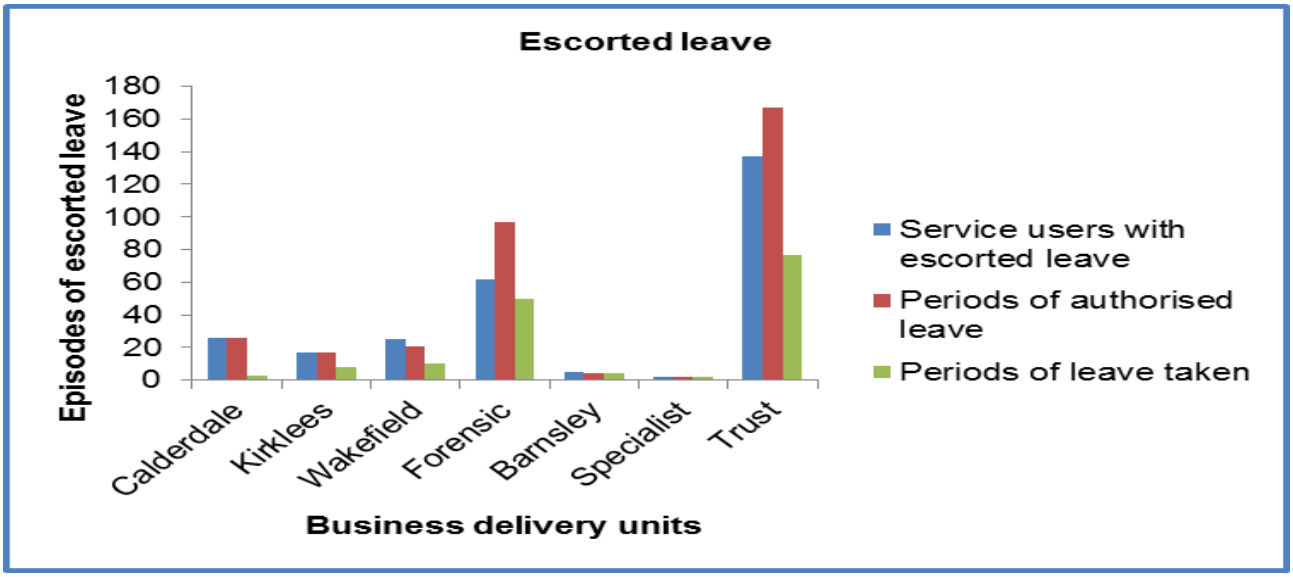
There are areas of concern about inclusion of Datix, RiO and NHS record numbers as well as names and designations of key staff members in some sections of the toolkit. We will be distributing the audit report to all BDUs and highlighting areas that need action or review. A re-audit is planned in quarter three of 2016-17.

B. Escorted leave

We conducted a snapshot audit of all service users who are given escorted leave on a particular date in December 2015. The aim was to determine whether escorted leave was authorised and took place as well as the reasons why if it did not.

The audit shows that almost half (46%) of those granted escorted leave were able to take it compared to 32% in the 2014 audit. The main reasons for not taking leave were that patients were unwell or they used the alternative Section 17 leave entitlement (unescorted leave).

The proportion of patients declining escorted leave fell from 45% in 2014 to 8% in this audit. And while 26% of cancelled leave was due to staff issues in 2014, this fell to 9% in 2015.



Forensic services authorised 97 periods of escorted leave for 62 patients. Forty seven patients did not take leave for a range of reasons, including low staffing and patient illness. This raises the question of how much escorted leave the standard staffed ward can manage on a daily basis. Further analysis is recommended of situations where staffing issues prevent escorted leave from happening.

C. Community treatment (Section 132A)

An audit was undertaken in January 2016 involving all community mental health teams – although the response rate was lower than anticipated.

Overall there was a high level of compliance although there are still some concerns about the reiteration and recording of patients' rights - raised as an issue in the previous audit in early 2015. However, oral feedback to the most recent audit suggests there is now a much greater awareness of its importance. Our audit also showed that several different recording processes are in place across the Trust.

The audit also showed that the rate of recalls is declining year on year although the rate of revocation remains high. However, the length of admission following revocation is still around three weeks shorter than admission under the MHA section 3.

It is recommended that the revised Patient's Rights Policy should be rolled out to provide a clear single Trust-wide recording system and that section 132A rights remain part of the annual audit work plan. We also recommend that all qualified staff working with Community Treatment Order (CTO) patients should receive annual training on these issues.

D. Consent to treatment

The annual audit of consent to treatment took place between December 2015 and January 2016 across all mental health inpatient wards.

The audit showed a significant improvement in recording assessments of the capacity of users to consent to treatment in relation to T2 (certificate of consent to treatment) requirements, with 92% of service users having a record.

In addition recording of consultation with the Second Opinion Appointed Doctors (SOAD) has risen from 50% in 2014 to 78% in 2015, although this still fails to meet the compliance goal of 81%.
Meanwhile 89% of the T2 sample and 78% of the T3 (certificate of second opinion) sample had a copy of the appropriate form on their medicine card. The fact that there was no certificate of authorisation attached to the medicine card in 17% of audited records is a cause for concern. In 94% of the T2 sample and 92% of the T3 sample the medicine card correlated to the relevant form.

It is recommended that consent to treatment remains part of the annual audit work plan and that it be expanded next time to include the recording of capacity statements at admission. A re-audit is planned for the first quarter of 2016-17.

What next?

We have identified the top 10 areas of concern about clinical information. A project initiation document is in development to address these issues. We will also develop a quality dashboard.

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?

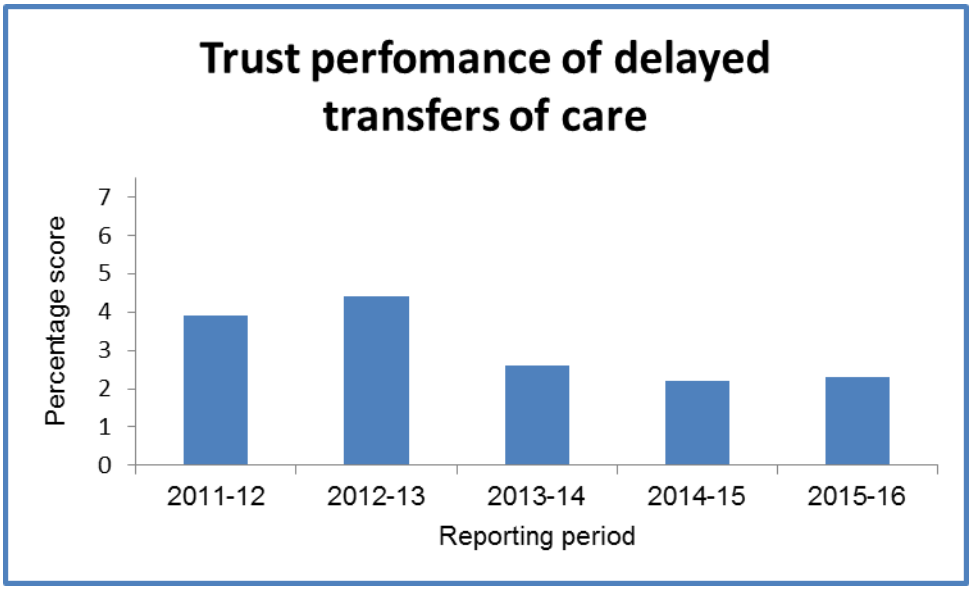
We monitored five key performance measures against this quality priority. The table on page 34-36 shows the progress we have made in this area.

Key performance measures 2015-16

1. Delayed transfers of care (DTOC)

A. Monitor performance figures

The Trust had a KPI goal for 2015-16 to ensure delays in patient transfer or discharge were no more than 7.5% of all discharges. This is a national goal, with a national definition that all trusts are required to achieve and our data is generated internally against the national definition.



The overall Trust figure for delays was 2.02% in quarter 1, 1.88% in quarter 2, 3.19% in quarter 3, and 2.33% in quarter 4, so comfortably achieving the goal in every quarter. Each BDU also reported DTOCs well below the 7.5% threshold. However, there have been spikes in monthly performance figures across the year.

Calderdale and Kirklees

Calderdale and Kirklees have a patient flow co-ordinator as well as two bed managers for each of their Intensive Home-Based Treatment (IHBT) teams. They work closely with the inpatient MDTs to ensure patients are closely monitored and discharged speedily.

The BDU holds weekly bed management teleconferences and promote discharge planning from the point of admission. In addition they produce weekly Sitrep reports on all aspects of patient flow, including DTOC. They also liaise with commissioners, co-ordinators, housing and any other partners to promote timely discharge.

Overall DTOCs in Calderdale and Kirklees were well below the 7.5% limit, although in Kirklees, the figures have been slightly above goal in 2016 and currently stand at 7.63%.

Learning disabilities

As the number of learning disability beds looks likely to be reduced, timely discharge becomes ever more important in giving flexibility over admissions.
Arranging discharges for people with learning disabilities can often be challenging. In addition, because of the small number of beds in the service a percentage goal can distort the picture - a single delay, for instance, pushes the service above its limit.

Despite this, delayed discharges, which were up at 28.99% in September, have been reduced to 0% over the last four months.

Wakefield

The Trust's standard operating procedure has been monitored and agreed through the Care Programme Approach (CPA). In addition each unit reports on its DTOCs every week. Monthly dashboards provide a regular check on any delays.

The number of DTOCs has consistently fallen in each quarter and currently stands at 0.36%.

Barnsley MH

Barnsley MH holds regular patient flow meetings as well as weekly inpatient handover meetings.

The patient flow meetings focus on improving patient throughput to ensure bed capacity is equal to admissions. The handover meeting uses a traffic light system to help in discharge planning. The template contains scores for each element of the patient journey from admission to discharge.

The annual rate of delays is below the 7.5% threshold although it currently stands at 7.08%.

Quarterly figures across the Trust

Q1	2.02%
Q2	1.88%
Q3	3.19%
Q4	2.33%

B. Implementation of the Standard Operating Procedure (SOP)

The Trust has produced a SOP aimed at minimising delayed transfers of care. It identifies a number of different reasons for delays, from waits for assessments, funding, care home places and home care packages, and offers advice on how to resolve them.

All BDUs have used the SOP this year, which has ensured we have consistent practice across the Trust. We review the SOP on an annual basis (or more frequently if required). We are currently considering suggested changes that would include a section devoted to criteria and guidance for transfers and the addition of local as well as Trust-wide goals.

2. Review and implement CAMHS protocols

The transition from children and adolescent to adult mental health services is a critical stage in good mental health care and we know that it is an area we need to improve.

For this reason we have instigated a Trust-wide review of our current transition protocol with the aim of ensuring a consistent process across all three of our child and adolescent mental health services (CAMHS). This will in turn mean a seamless and successful transition for users.

The protocol is directed at all clinical staff within both CAMHS and adult mental health services. It stipulates that young people can move into adult services when they reach 18 and that planning for that transition should start around six months earlier. It recommends that all staff should receive training for this and that case management should be the responsibility of the CAMHS care co-ordinator/ key workers until the transfer has taken place.

The stated objectives of the protocol are:

- Ensuring a seamless transition from child to adult services
- Promoting collaborative and flexible working practices between the two services
- Clarifying and defining the roles and responsibilities to service users in delivering effective risk management strategies
- Clarity not only for CAMHS and adult mental services but also GPs, social services and other agencies.

The protocol has now been adopted across all three CAMH services and implementation will be monitored through case note audits and regular reviews with the adult service managers.

The Trust has also set up a review team to assess how the protocol works in practice. The team will be led by the Assistant Director of Nursing and CAMHS practice governance coaches and will report back to the services' governance meeting.

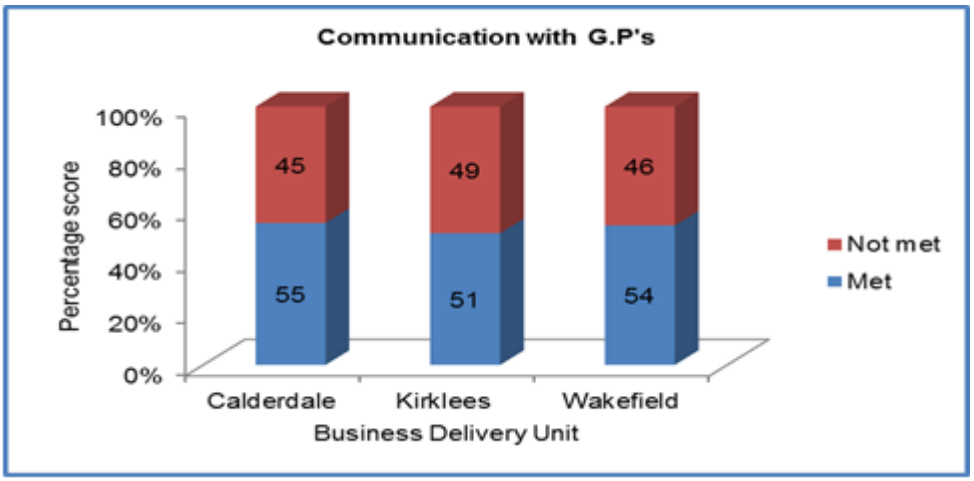
3. Improve communications with GPs: people on the CPA with a diagnosis of psychosis should have an updated care plan or a comprehensive discharge summary shared with GP

Good communications between mental health services and the client's GP are a core element of good care and can be important in ensuring an individual receives the right care and treatment.

For this reason we were happy to sign up to a national CQUIN requiring 90% of patients with a diagnosis of psychosis to have their updated CPA care plan or comprehensive discharge summary shared with their GP.

It was agreed that compliance would be tested by an audit of 100 service users at the end of the second quarter. In order to meet the CQUIN standard services we have to fulfil all of the following conditions:
1. Care plan/discharge summary to GP within last 12 months
2. NHS number
3. All primary and secondary mental and physical health diagnoses to include ICD codes and/or READ codes
4. Medications prescribed and monitoring undertaken
5. Physical health condition identified by mental health services, with a corresponding healthy lifestyle plan
6. Recovery-focused healthy lifestyle plans.

The results were:



The figures show we fell well below the 90% goal. However, it should be noted that most cases that failed to meet the standard nevertheless fulfilled four or five of the conditions. The third condition

caused most problems and work is now under way with GPs to obtain the ICD/READ codes for any physical health diagnosis.

This CQUIN will be carried over to 2016-17. We are developing plans to support improvement.

4. Implementation of the CPA framework in CAMHS

The CPA is a person-centred framework for care designed for those with complex mental health care planning needs. Although it is not commonly used for children and young people, the Health Department says that a modified approach would be appropriate.

Our CAMHS are in the process of introducing this approach. In 2015-16 we decided to focus on three areas that would in our view have the greatest impact on effectiveness and safety:

- Everyone to have an assessment of need on the electronic recording system (RiO) rather than on paper
- Care planning to be recorded on the electronic recording system
- Clinical outcomes to be recorded on the electronic recording system.

Trust leads have now begun to review our use of RiO and the CPA and steps are being taken to embed this as a standard approach to practice. We have been helped by recruiting new clinicians who are familiar with both the CPA and RiO and who can pass on their knowledge to other staff.

The CAMHS project lead for quality improvement and assurance and practice governance coaches have offered one-to-one mentoring and coaching in RiO. In addition a single document of relevant information has been created to guide staff.

This can now be accessed in a variety of ways including via the intranet, through face-to-face training, video links and flow charts. We also have a policy and procedure guide to the electronic record system, clinical risk management and recording of risk and CPA standard operating procedures.

We also plan to look at further training for CAMHS staff as well as more mentoring and coaching. We are in the process of developing a Trust-wide CAMHS service operating procedure which will include standards for the use of RiO and CPA. Local team action plans have been drawn up in all areas. We plan to repeat the clinical records audit in the third quarter of 2016 -17 which will assist with the monitoring of CPA.

5. Development of an Intermediate Care Service (Barnsley Community & Well Being)

In the last 12 months we have been assessing the quality of our Intermediate Care Services in Barnsley BDU through a range of patient and public involvement measures as well as engagement with staff and partners.

This is part of a new intermediate care specification which will be operating in shadow form until September 2016.

The 2015 National Audit of Intermediate Care revealed that all three elements of our Intermediate Care Services had quicker response times, from referral to assessment or start of treatment, than the national average.
Our Hospital at Home Patient Reported Experience Measure (PREM) scores were also above average – while costs per service user on our two Mount Vernon wards were below the national average.

All this is against the backdrop of significant challenges over the year with the number of independent sector beds falling from 30 to 25 and Trust staffing levels also being reduced by 5.9wte.

In terms of patient and public involvement we conduct Rapid Response and Hospital at Home PPI surveys twice a year and generate action plans from these. We also do monthly Friends and Family Tests across all of our services.

On our Mount Vernon wards we carry out patient surveys on discharge as well as monthly patient listening events and encourage use of our comments and suggestions boxes to inform our 'You Said We Did' initiative. We also offer therapist drop-in sessions for families. Our 'Making it Real' baseline audit involved self-assessment alongside input from patients, families and carers and this is all fed into our action plans.

We have held staff engagement events and intermediate care workshops as well as working closely with commissioners and partner agencies. For instance, we held a workshop recently with ILAH (Independent Living at Home) colleagues to discuss the development of pathways. We also liaise with non-statutory bodies such as independent sector care homes.

Over the last year we have developed a training plan for staff and a skills audit matrix. These have helped formulate a BDU-wide learning and development plan.

We will continue to focus on quality as an integral part of service provision. We are also developing a PPI questionnaire to elicit the views of independent sector care home residents.

What next?

We will continue with our mission for 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. The areas for focus in 2016-17 will be to continue the work started on transitions in CAMHS services and update our work on transitions between learning disability and mental health services.

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

Why did we focus on this?

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 two key performance measures against this quality priority. The table on page 34-36 demonstrates the progress we have made in this area.

Key performance measures 2015-16

1. Implementation of Trust-wide clinical supervision audit

Clinical supervision is described in the Trust's policy document as "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 means focused support and development."

To establish how well this was being applied in practice we decided to carry out an audit between August and September 2015. A total of 352 qualified nurses took part.

We found that some teams within the Trust have a process in place to ensure there is genuine clinical supervision. However, it is still not undertaken as it should be in some areas.

Overall we found that 81% of our nurses in the audit sample received clinical supervision, with the highest percentage recorded in Barnsley BDU (95%). In a third of cases across the Trust clinical supervision is undertaken jointly with management supervision (which is not in line with the policy). Two thirds (67%) receive one-to-one supervision, 5% are in groups and 28% have a combination of the two. Just over half receive supervision from within their own teams and another 42% in their own BDU or another BDU or directorate within the Trust.

Reasons for nurses not accessing clinical supervision include not understanding its importance and not having the protected time to attend.

Just under half of respondents have monthly supervision sessions and most (69%) receive supervision for an hour while 27% have sessions lasting between one and two hours. The policy requirement is 12 hours a year for nurses.

Just over half (53%) of potential supervisors provide clinical supervision, of whom 63% offer supervision to between one and three supervisees. Over a quarter (28%) carry out group supervision.

A total of 116 qualified supervisors said they had not offered clinical supervision because nobody had approached them asking for it. This is often because nurses are unsure who is qualified to provide it.

The auditors have made a number of recommendations to improve the quality and quantity of clinical supervision, including:

- Clinical supervision leaflets to be distributed to all qualified nurses as part of their induction
- Team managers to identify staff with the skills to provide supervision
- A list of qualified clinical supervisors to be available on the intranet
- Ensuring all nursing staff have protected time for clinical supervision
- Team managers to conduct annual audits of compliance
- Re-audit of nurse clinical supervision in December 2016.

The audit report, including recommendations, has been disseminated through the BDU governance groups and services have been asked to implement the recommendations most pertinent to their service.

2. Staff Friends & Family Test. Percentage of scores recommending:

1. Trust as a place to work

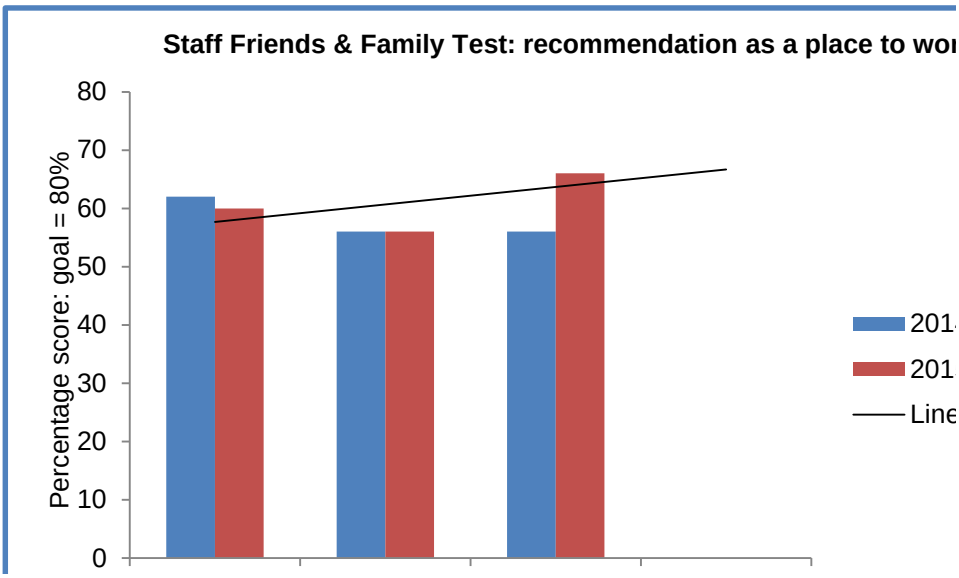
2. Trust as a place for care and treatment

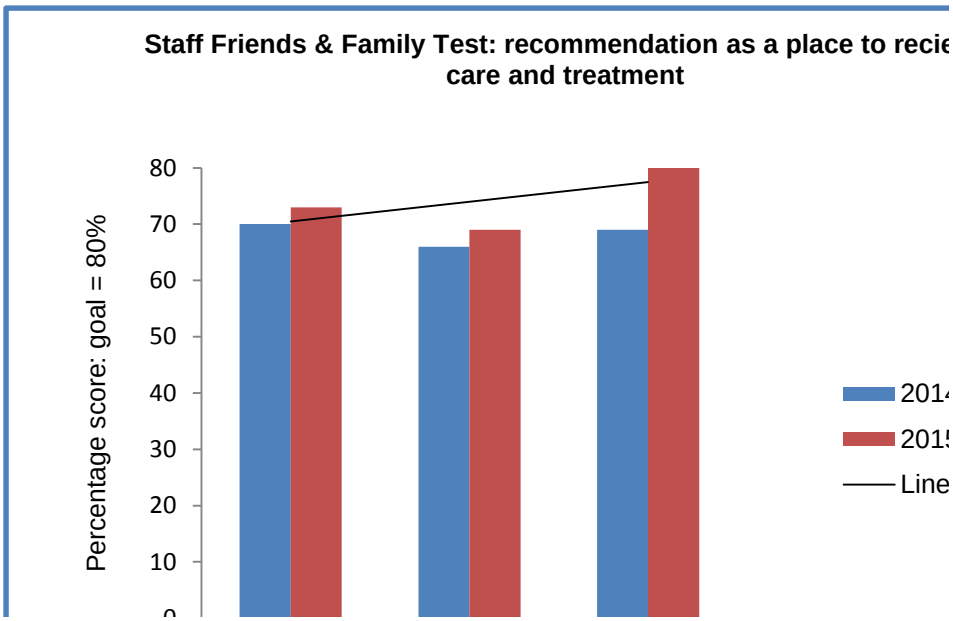
The Staff Friends & Family Test was introduced in April 2014 as part of the national implementation of the FFT. We used locally generated data against this national definition for our measure. Staff FFT asks two questions:

- How likely are you to recommend the Trust to friends and family as a place to work?
- How likely are you to recommend the Trust to friends and family if they needed care or treatment?

The percentage of staff recommending the Trust as a place to work fell below the 80% goal in each of the three quarters when the question was asked, with the highest proportion (66%) being in the final quarter. Staff were more positive about recommending us for care and treatment, with 72.5% being likely or extremely likely to recommend it in the first quarter, 69% in the second and 80% in the final quarter.

The following charts show how we have performed in the staff FFT test over the past two years.



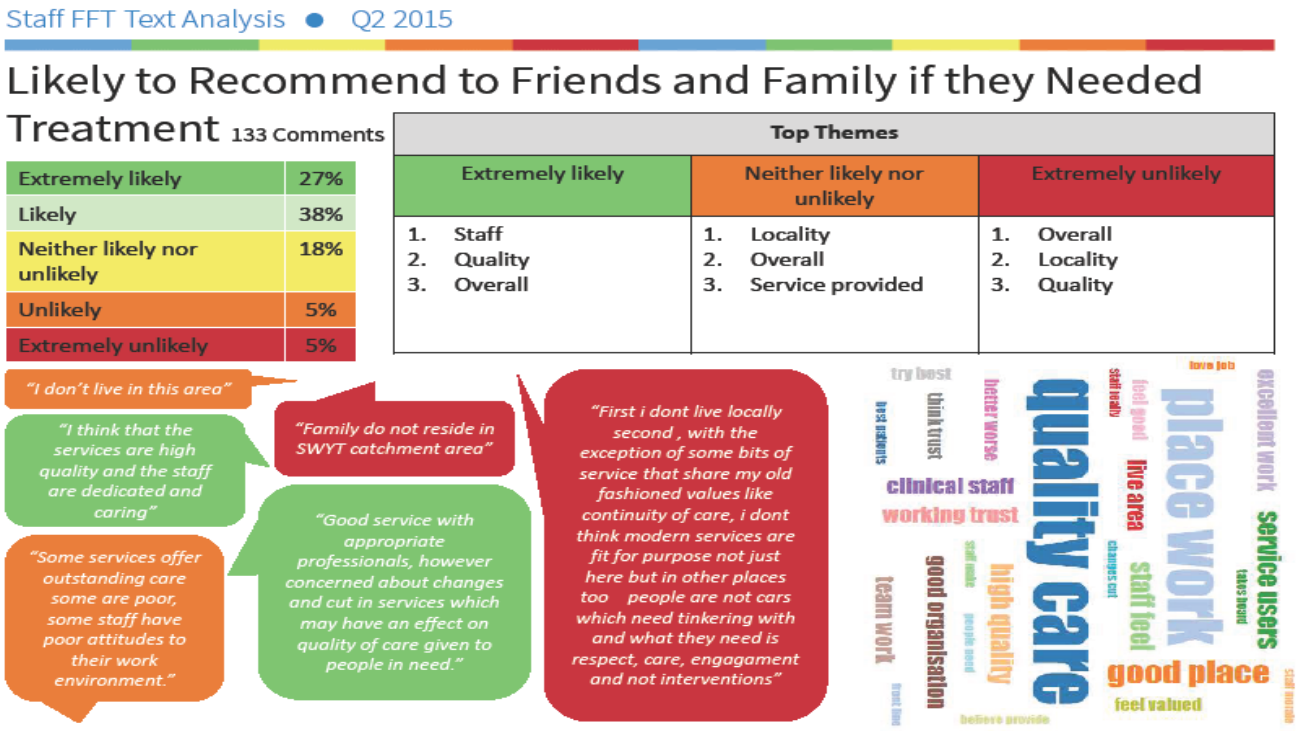


Positive comments in the feedback section included 'caring staff', 'good place to work' and 'job satisfaction'. Others commented unfavourably on changes happening in the Trust and NHS as well as job insecurity and management support.

In 2015-16 we have acquired a system for analysing our staff FFT feedback. The following is an example of a report that can be created from the system. We are currently working to refine the reports, which will be included in the Trust's quality reports in 2016-17. (see FFT text analysis Q2 overleaf)

Many of the FFT themes were also highlighted in the 2015 NHS staff survey results which showed staff satisfaction with levels of resourcing and support to be above average while work-related stress was lower than average. Staff satisfaction with patient care and the quality of work was

higher than average. The effectiveness of communication between senior management and staff was identified as an area for improvement.



The 2015 Well Being at Work survey conducted by occupational psychologists Robertson Cooper, highlighted job security and change issues as the greatest area of concern for staff along with lack of involvement in decision-making in some areas of the service. However, satisfaction with resources and communication issues had improved as had reported levels of physical health. There was also positive feedback on personal well-being and resilience.

We have taken a number of initiatives to address issues of concern, including:

- Ongoing investment in staff development, including more opportunities for staff supervision
- Investors in People review conducted in 2015
- Development of a Nursing Strategy
- Middleground 4 leadership development programme
- Leadership and Management Strategy and significant investment in leadership and management development activity
- Staff Engagement Strategy agreed in 2015
- Introduction of band 2 apprentices in the Forensic BDU and recruitment of additional staff in CAMHS.

The next Well Being at Work survey will be launched in May 2016. There are also plans to align the staff and users FFT so that feedback can be reviewed jointly.

What next?

By ensuring our staff feel valued, fit and well we know they are more likely to provide consistently excellent care. In 2016-17 we will focus on improving health and well-being of NHS staff as stated in

the national CQUIN, continue monitoring Staff FFT feedback – focusing on the percentage of staff commending the Trust as a place to work and monitoring the number of staff who access Mental Capacity Act / Deprivation of Liberty training.

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?

We monitored four key performance measures against this quality priority. The table on page 34-36 demonstrates the progress we have made in this area.

Key performance measures 2015-16

1. **Mental health safety thermometer**

We continue to lead the way in our use of the mental health safety thermometer, a national tool that has been designed to measure commonly occurring harms in mental health service users. It is a point of care survey, carried out one day per month, which supports improvements in patient care and patient experience, prompts actions and integrates measurement for improvement into daily routines.

The tool measures:

- Self-harm within the last 72 hours
- Victim of violence within the last 72 hours
- Medication omissions within the last 24 hours
- Psychological safety.

In addition inpatient services also keep monthly data on the incidence of restraint within the last 72 hours.

Eligible teams in the west of the Trust have been fully involved in collecting data for the safety thermometer for the past two years, as part of a locally agreed CQUIN. Meanwhile all forensic service teams were fully compliant by half way through the year. It is hoped that our child and adolescent mental health services (CAMHS) will begin collecting data shortly.

Nationally we appear to be significantly the largest inputter of data. We now average 750 data collections a month - almost double that of any other Trust. We also advise and support other trusts on how to roll out the use of the safety thermometer or employ the data and, in some cases, how to use the thermometer for CQUIN funding.

Figures show that the Trust benchmarks favourably with other trusts on most measures [NB Figures can be downloaded from the national site which is updated monthly.] However, we have not performed so well on inpatient medication omissions, so this year we focused particularly on this measure.

As a result, the proportion of both community and hospital patients who have missed a medication in the last year (Oct-Nov) has fallen and is now in line with the national median of 12.1%. In quarters 1 to 3 our rate was below this level for five months and only rose above it in three months. In quarter 4 we missed this goal by 3%.

Our immediate aim is to reduce inpatient medication omissions even further and to promote awareness among all staff through training and communications strategies.

2. Implementation of Sign up to Safety campaign – progress report

In the last year we have started to implement an ambitious patient safety improvement plan aimed at enhancing the safety culture in the organisation and reducing avoidable harm to patients.

Our Sign up to Safety 2015-18 action plan will be delivered as part of the Trust's new Patient Safety Strategy and is based on five key pledges:

1. *Put safety first*
We will develop a Trust-wide patient safety strategy aimed at preventing harm and making safety a priority for all staff.

2. Continually learn
We will foster a culture of learning from patient safety incidents and demonstrate real changes in practice as a result.

3. Honesty
We will be open with service users and carers when harm has occurred, share lessons learned and communicate what we've done to stop it happening again.

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

5. Support
Service users, carers and staff will be offered support after untoward incidents.

As part of the implementation plan we will publish the actions we undertake in response to these five pledges on our website. We will also identify specific patient safety improvement areas, taking into account national high priority issues and our own local needs.

In addition we will engage with the local community, patients and staff to ensure the focus of our plan reflects what is important to the community. We will make our plan public and produce regular updates on progress.

The key areas for improvement are:

1. Falls – goal: to reduce falls by 15% by 2018 and injuries or deaths from falls by 10%
2. Medication omissions – goal: to reduce unintended missed doses by 25% by 2018
3. Pressure ulcers – goal: to reduce avoidable incidents of pressure ulcers by 50% by 2018
4. Prone restraint – goal: to reduce the use of prone restraint and the level of harm when used
5. Injuries following physical restraint – goal: to reduce incidents resulting in moderate or severe harm by 30% by 2018.

We are tackling these in collaboration with Yorkshire and Humber Academic Health Sciences Network and the newly-formed Yorkshire Patient Safety Collaborative.

3. Forensic services: cardio metabolic assessment and treatment for patient with psychoses

People with mental disorders are recognised to have poorer levels of physical health in many areas. The Forensic BDU has been involved in a range of activities aimed at improving our users' physical health care and outcomes.

We administer a health screening for all users soon after admission and repeat this annually. The screening involves cardio metabolic assessment and treatment, including:

- Smoking status
- Lifestyle including exercise, diet, alcohol and drugs
- Body mass index
- Blood pressure
- Glucose regulation
- Blood lipids.

In accordance with CQUIN goals we completed our implementation plan by the end of July 2015 and fully implemented a training plan for clinical staff by January 2016.

At the end of the third quarter a random sample of 18 users were selected for the national audit. Latest data shows that 100% of our sample met the end of year goal. In addition we achieved our 90% goal for assessment and treatment compliance in the fourth quarter.

4. Learning disability: cancer screening (Barnsley services)

A significantly lower proportion of people with a learning disability access screening services for cervical, breast and bowel cancer than the general population.

For this reason Barnsley was given a CQUIN goal last year (2014-15) to improve uptake, which it achieved. However, uptake is still below the national average so a new CQUIN was devised for 2015-16 which sought to bring uptake to within 5% of the national average. Data for this measure was generated internally against the local CQUIN goal.

Over the course of this year we have undertaken a range of measures to improve uptake. As a result we achieved the new goals for cervical and breast screening although we just missed out on the bowel cancer screening goal.

Cervical

Community learning disability (LD) nurses have worked with GP practices to help them understand the Mental Capacity Act. This has included discussions to determine the best interests of those clients who lack capacity to make decisions.

Where necessary LD nurses have worked with acute liaison nurses and staff at Barnsley Hospital to ensure reasonable adjustments are made to enable people to receive a good outcome.

Our goal was to ensure 63% of eligible people with learning disabilities received screening. Taking into account exceptions, this goal was achieved.

Breast

We have worked with Barnsley Hospital Women's Services to improve breast cancer screening for people with a learning disability. We informed practices about patients with learning disabilities and sent out easy to read letters when they were called for appointments. We also arranged for women to look around the clinic before their screening if they wished.

If for some reason a mammogram could not be carried out, then advice was given about what to look out for. The healthcare facilitator within the community LD team supports women who have not attended screening before. This has given them confidence to report anomalies to their GP.

The goal was 73% screening uptake which, when exceptions are taken into account, we met.

Bowel

We have worked closely with individuals and their carers to increase understanding of bowel cancer and the importance of screening. However, this is still a difficult area and many remain reticent about undertaking the screening test. As a result we did not reach our 41.6% goal – although the proportion that did go for screening (39%) still represents an increase on last year.

What next?

We want to make sure the people who work with us and visit us are safe from harm. In 2016-17 our focus will be to improve the physical health of patients with severe mental illness (PSMI), implement our suicide strategy, ensure our wards are staffed with the correct numbers and skill mix of staff (safer staffing) and continue with the implementation of the mental health safety thermometer.

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
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.
BME	Black or minority ethnicity
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
CAPE	Clinical Audit and Practise Evaluation
CCG	Clinical Commissioning Group
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.
HONOS LD	Health of the Nation Outcome Score for Learning Disability
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
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
NIHR	National Institute for Health Research
NHSE	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
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
PREM	Patient Reported Experience measure p60
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.
SSNAP	Sentinel Stroke National Audit
STPs	Sustainability and transformation plans
SystmOne	clinical information system for community services

Please visit: **www.nhsconfed.org / acronym-buster**

Annexes

Annex 1: Statements from our stakeholders

Wakefield Overview & Scrutiny Committee

South West Yorkshire Partnership NHS Foundation Trust Quality Account 2015/16

Feedback from Wakefield Council's Caring for Our People Overview & Scrutiny Committee

Through the Quality Accounts process the Caring for Our People 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 has noted the results from the 2015 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 supports actions to improve performance in this area as outlined in the Quality Account including the internal well-being at work survey.

The Committee welcomes steps to increase accessibility to the Friends and Family test, particularly for young people and supports the planned further improvements highlighted in the Quality Account. It is particularly pleasing to note that feedback from people who use the Trust's services consistently highlight the caring nature of staff.

The Committee agrees with the statement within the Quality Account that individualised personal care is essential to a person's recovery and supports the key performance measure of people with a mental health need who have had an assessment of their need and been allocated a care pathway within eight weeks. The Committee note that the Trust failed to meet this demanding target in 2015-16 but recognises that the margins were small in Wakefield. The Committee supports actions to review underperformance in this area and actions to mitigate risks.

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 has received assurances in relation to proposals regarding Savile Park View House in that the necessary Quality Impact Assessments had been undertaken prior to any decision being made on the possible closure of the facility. The Committee agrees that this rigorous challenge process helps safeguard quality and that the re-provision of this service in alternative ways, close to home and away from a hospital setting would provide better care and improved quality of service locally.

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 have noted progress made against the Future in Mind Wakefield Transformation Plan and the work that had been implemented locally to improve access to mental health and wellbeing services for children and young people. In terms of local priorities within the Plan the Committee feels that reducing the incidence of self-harm could be given greater recognition in terms of action and resources.

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 therefore welcomes the actions within the Quality Account to support this aim.

The Committee welcomes the positive feedback from the Care Quality Commission (CQC) recent inspection, in particular the positive comments in relation to ADHD service, CAMHS and older people's wards. However, the Committee notes the CQC's concerns around safer staffing and looks forward to the further reassurance reflected in the Trust's safer staffing report, the evidence based staffing tool and other information in respect of staff surveys etc.

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 satisfied that the Quality Account is supported by relevant data and provides appropriate evidence of the Trust's quality improvement progress.

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

Calderdale & Huddersfield Foundation Trust

Re: Quality Account 2015/16

Thank you for your email enclosing the 2015/16 South West Yorkshire Partnership NHS

Foundation Trust Quality Accounts. Firstly, I would like to say that the overall document is very well presented and the content reads well.

I support the Quality Account priorities, particularly care of people with dementia and improved access to Mental Health services. I would like to congratulate you on your performance in

2015/16 priorities and welcome an extension into 2016/17 of those where more improvement can

be made.

I have detailed below the three priorities for Calderdale and Huddersfield NHS Foundation Trust

for 2016/17; these are areas we recognise as being important to patients we treat.

Domain	Priority
Safety	Falls
Effectiveness	Mortality
Experience	Community Experience

Yours sincerely

Juliette Cosgrove

Assistant Director for Quality

Calderdale, Kirklees and Wakefield Clinical Commissioning Group's.

South West Yorkshire Partnership Foundation Trust Quality Accounts Feedback 2015/16

Thank you for providing the South West Yorkshire Partnership Foundation Trust (SWYPFT) Quality Account 2015/16 for comment. The Quality Account has been shared with members of the Clinical Commissioning Groups who attend the SWYPFT Quality Board and their comments incorporated into this statement.

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 organizational context for how this is managed and the Trust's quality ambitions.

We support the continuation of the high-level quality priorities, with the focus on specific measures for 2016/17 within those priorities. The CQUIN scheme we have co-produced with SWYPFT supports achievement of the Trust's quality priorities.

We were pleased to see, in the Statement from the Chair and CEO, feedback from CQC about the caring nature of staff and the positive moral which has been achieved in spite of an extremely

challenging environment. We await the receipt of the CQC inspection outcome and look forward to being involved in the oversight and delivery of any resulting action plan.

The quarterly quality report produced by the Trust is reviewed at the Quality Board and there has been discussion about a number of the Trust's key priorities, particularly care planning, staff engagement and patient safety. We have had sight of other documents outlined in the account, including the Patient Safety Strategy.

The section on clinical audit describes in detail the local audit programme. However, it would have been useful and relevant to give some examples of improvements implemented as a result of audit findings.

Priority 2: Timely access to services (Access)
We welcome access to care as a continued priority. We still have some concerns and continue to have feedback from patients and GP referrers about difficulties accessing some Trust services; this is also reflected within performance. 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. We trust that SWYPFT will continue to engage with commissioners around finding a solution to this ongoing issue.

Priority 3: Improve care and care planning (Care planning)
We acknowledge the on-going challenge in relation to person centred approach to care planning. This priority was partially achieved with progress made throughout 205-16. We are glad to see this is being included in the Quality Priorities for this coming year and we hope that SWYPFT continue to build on the good work that has already been started. It would be good to understand the variance seen between the Business Development Units for this indicator and see a plan for how lessons can be learned from the work done in Wakefield. We would encourage the Trust to develop opportunities for shared learning across BDUs in order to continuously improve practice.

Priority 7 - Improve the safety of our service users, carers, staff and visitors.

We welcome the inclusion of Safer Staffing as an indicator for this priority and acknowledge the work SWYPFT have done to develop a local safer staffing tool. Although this is positive, challenges continue in relation to vacancies and sickness levels in some areas and use of agency staff. We will continue to monitor safer staffing levels as commissioners.

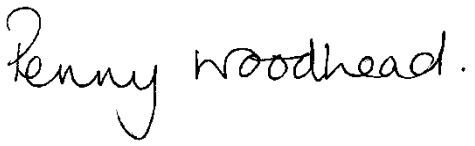
Data Quality and RIO
We welcome a focus on data quality and accurate record keeping and we are pleased that there is commitment to optimise the use of this in order to make the systems easy to access and use. Although this is challenging we see this as a vital component to delivering good quality, safe care.

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.

The account contains some really good examples of partnership working across sectors and within health and academia and we look forward to seeing the results from the on-going work of Sign up to Safety, and transformation programmes.

Overall we feel that the challenges ahead have been identified by SWYPFT. 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

Wakefield Healthwatch

Commentary on South West Yorkshire Partnership NHS Foundation Trust Quality Account 2015/2016

Thank you for the opportunity to comment on your Quality Accounts for the year 2015/2016. In order to provide commentary, information and intelligence has been collected by a variety of mechanisms including our standing task group on Quality Accounts and the information contained in the Public Voice Report to the Health and Wellbeing Board, January 2016. The task group would have liked to have met with the Trust representatives (as in previous years) but unfortunately this did not materialise for a variety of reasons. We would very much like this to happen in future years.

The Trust has continued to provide a very caring service. At Healthwatch Wakefield we have recorded comments like:

> "Fieldhead hospital. I spent some time in there. The staff were brilliant. Really helpful and the staff were friendly. I had my own room. They were always there when I needed them. Fantastic place and people".

> "My wife has dementia. Everything they (in Connecting Care Team) did I cannot praise them enough, superb service."

But there are some adverse comments too.

Woman with two sons – told two year wait for autism assessment for her younger son (oldest already assessed as autistic). Wanting to know what she's supposed to do in the meantime, concerned about support that they could be getting to help with his (and her) ability to cope. Both boys exhibit challenging behaviour and mother has ME so finds it hard.

> "I had a support worker from the Community Mental Health Team. But they have stopped that service for me (I think due to cuts). I now have gotten worse. I have had to use the emergency crisis team many times. In order to get to see the emergency crisis

team (at Baghill House, Pontefract) you have to be referred to them by a GP. This is usually really difficult to get, not least because you cannot get to see a GP quick enough. I feel abandoned, I have no one to contact if I am in crisis. There is no one."

"My daughter suffers from mental health issues. After many months of trying to get help, she eventually got into the system and was attending Horbury Health Centre to see a doctor. In the information leaflets we received it stated that you would always see the same doctor (3 appointments so far, 3 different doctors). These appointments were an interim period, up to her getting seen by a psychologist. When I chased this up, I found out that she had dropped out of the system. Don't know why."

We have also heard a number of concerns about the CAMHS service, including long waiting times, discharge and communication issues among others. We are pleased that work is being done to make improvements to this service.

The draft Quality Accounts 2015/2016 is a good document, easy to read and understand, although we did feel that a glossary of terms would be a very good addition. We also thought that a short summary would be useful as this document is very long.

It is clear that most of the priorities for the year 2015/2016 have been achieved, but we would like to point out the following items:

1) Page 13 - Duty of Candour – The document defines the policy very clearly but unfortunately it is not clear if there were any breaches in this duty in the year 2015/2016.
2) Although the full CQC inspection report is not yet available, their initial findings are very much in line with our intelligence, for example concerns about waiting lists and CAMHS psychological therapies. We note that verbal feedback from the inspection indicated that staff were caring which is very important. We would like to suggest that in relation to their comment on physical health monitoring that life expectancy of all patients with mental illness and learning difficulties is reduced and therefore steps should be taken by all organisations looking after these patients to improve life expectancy. (see note 8)
3) Page 17 – National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness 2015/2016, we note that only 78% of the cases were submitted for the inquiry with not all nine outstanding questionnaires accounted for.
4) Page 24 - Readmission rate - It would be interesting to be able to see a benchmark against national readmission rates and lowest and highest figures.
5) Page 25 – 20%/23% of white/BME staff experiencing bullying from other staff seems high.
6) Page 27 – Patient safety incidents - It would be useful to see these figures per 10,000 bed days or per 100 admissions. We see that the Trust is a good reporter being ranked 117 out of 230, but we were interested to know what the national mean reporting rate is.
7) Page 56 – Review and implement CAMHS protocols - Our intelligence from a variety of sources confirms the problems faced by patients in this process. We hope that the review is completed quickly and we will be monitoring progress.
8) Page 65 – As mentioned earlier we are concerned with the low life expectancy in all mental health and learning disability patients and not just in Forensic Services. We wonder whether it is possible to administer a health screening for all users soon after being seen (irrespective whether admitted or not) and repeated annually.

We feel a few items as listed below are missing from the quality account:

1) Are there any patient safety alert warning issues and are you compliant with them?

2) Are you compliant with all the NICE recommendations?
3) Are most of the staff appraised annually?
4) Are the fully registered doctors re-registered after every 5 years?
5) Are there any never events in the Trust in the reporting period?
6) Have you considered monitoring always events as suggested by Institute of Health Improvement?

In relation to your priorities for 2016/2017 we wondered why Priority 5 does not include a commitment to improving care pathways with other services, not just services within the Trust. The system approach to healthcare in Wakefield District would suggest that services need to integrate and communicate much more effectively. Other than this, we felt that the priorities continue to be very appropriate.

Barnsley Clinical Commissioning Group

Barnsley Clinical Commissioning Group (CCG) has reviewed South West Yorkshire Partnership NHS Foundation Trust's 2015-16 Quality Account.

Our view is the Quality Account is presented in a clear and easy to read format, includes all essential elements and covers the formal requirements for quality accounts and quality reports, based on the quality accounts legislation and Monitor's additional requirements for quality reports.
To the best of our knowledge, the report appears factually correct. As in previous years, the CCG would welcome greater transparency in relation to Barnsley specific data.

It is the view of the CCG that the Quality Account reflects the ongoing commitment from South West Yorkshire Partnership NHS Foundation Trust to quality improvement and addressing key issues. The CCG notes the priorities that South West Yorkshire Partnership NHS Foundation Trust has identified for 2016/2017 and looks forward to more granular level data to understand how this translates into outcomes for the people of Barnsley.

The CCG acknowledges and commends:
- the Barnsley 'end of life' care team being shortlisted for the 'Multi-disciplinary teamwork award category at the 2015 international Journal of Palliative Nursing awards

The CCG notes and commends the improvement in initial access to CAMHS in Barnsley and anticipate the work in 2016/17 to reduce access times to therapy appointments with a greater focus on outcomes and also work to develop transition to adult services.
Whilst noting the work undertaken in the last year around Intermediate Care Services, in particular quicker response times and positive PREM scores, we must highlight that there is further work to be done to clarify the focus of the service and how it enables prevention of hospital admission, earlier discharge, reduced lengths of stay and also charting functional outcomes.

We were surprised that no mention has been made of the key role South West Yorkshire Partnership NHS Foundation Trust have made to RightCare Barnsley through our alliance contract which has now been extended into its second year and exemplifies the integrated working we are seeking to make the norm. And as of yesterday has received national recognition in the HSJ Awards Value in Healthcare Awards.

We also want to highlight the positive way in which South West Yorkshire Partnership NHS Foundation Trust have engaged in the Community Nursing Review to develop a new specification but note the challenges this will bring in 2016/17 to focus on outcomes for patients and relationships with Primary Care.

The CCG note the Trusts management of Serious Incidents and assurance processes and the ongoing work to ensure there are improvements in patient safety and the Trusts reported position as 'good' and the NHS Improvement ranking of 117/230 in terms of incident reporting culture.

The CCG notes the 2015/16 priorities for improvement which were not achieved and the plans for further development in these areas, in particular in relation to care planning. Building on previous investments, the CCG has also agreed three CQUIN's for the year ahead, these are; Mental Health Clustering, Community Nursing Review and the management and prevention of falls.

We will continue to support the Trust to drive improvements in patient safety through projects and collaboration to focus on local priorities and minimise potential risks. In particular, NHS Barnsley CCG are supporting the Trust to continue to build on their success to date in the reduction in the number of falls resulting in moderate or severe harm with a Falls CQUIN scheme which aims to see a reduction in the number of in-patient falls.

Over the coming year, the CCG look forward to supporting the Trust to further embed trust wide learning and improvement from incidents, including Never Events, themes from complaints and placing more focus on the implementation of action plans, lessons learned and sharing good practice across the organisation.

We have a structured bi-monthly quality review meeting (Clinical Quality Board) with the Trust, and review a range of indicators and metrics from a number of sources.

The CCG will continue the planned Quality Assurance visits and engagement with the Trust to enable the Trust to showcase improvements and identify areas on which to focus.

Yours sincerely

Martine Tune

Deputy Chief Nurse/Head of Patient Safety

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 2015-16 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 2015 to March 2016
  - papers relating to Quality reported to the board over the period April 2015 to March 2016
  - feedback from commissioners dated
  - feedback from local Health watch organisations dated
  - feedback from Overview and Scrutiny Committee dated
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009:
    - Annual report for 2014-15
    - Quarterly reports 2015-16 : July 2015 (Q1); October 2015 (Q2); January 2016 (Q3)
  - The national community mental health patient survey 2015
  - The national staff survey 2015
  - The Head of Internal Audit's annual opinion over the trust's control environment dated
  - CQC Intelligent Monitoring Report dated June 2015 & February 2016.
- 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

..25 May 2016.....Date.....  .....Chair

..25 May 2016.....Date..... .....Chief Executive

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

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

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

Scope and subject matter

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

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

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

Respective responsibilities of the directors and auditors

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

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

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

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

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

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

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

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

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust annual reporting manual'.

Deloitte LLP

Chartered Accountants

Leeds, UK

26 May 2016

Data entered below will be used throughout the workbook:

Trust name:	South West Yorkshire Partnership NHS Foundation Trust
This year	2015/16
Last year	2014/15
This year ended	31 March 2016
Last year ended	31 March 2015
This year commencing:	1 April 2015

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").

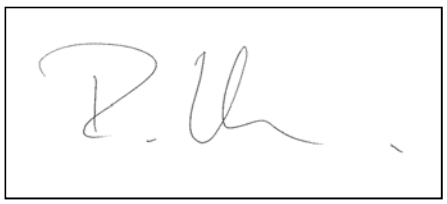
Under the NHS Act 2006, Monitor has directed South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view 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……

Rob Webster Chief Executive Date 23 May 2016

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…… ……
Rob Webster Chief Executive Date 23 M

Signed…… ……
Jon Cooke Interim Director of Finance Date 23 M

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 2016 and of the Group's and Trust's income and expenditure for the year then ended; •have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and •have been prepared in accordance with the requirements of the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cashflows and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate	We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Going concern	We have reviewed the Accounting Officer's statement contained on page 72 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.**:**
NHS Revenue There are significant judgments in recognition of revenue from care of NHS Service users due to the judgements taken in evaluating the Trust's entitlement to Commissioning for Quality and Innovation (CQUIN) income. The total CQUIN premium earned in the year was £3.5m (2015: £4.5m) and represented achievement of 18 performance measures agreed with the Commissioners of the Trust's services. The income earned is included in the balance of 'Income attributed to CCGs and NHS England' disclosed in note 5.1 Income from Activities and recognition governed by the accounting policy set out at note 14. In the prior year the risk associated with revenue recognition was focussed upon incremental adjustments to the Trust's revenue contracts arising during the year and particularly where judgement was exercised as to whether, and the extent with which, revenue should be allocated to current of future accounting periods. In the prior year the total of such contract variations totalled only £0.04m and our planning work indicated that the total of such adjustments in the current year was likely to be of a similar magnitude. This led us to conclude that it was unlikely that these incremental adjustment would continue to give rise to a risk of material misstatement.	We evaluated the design and implementation of controls over the negotiation, agreement and monitoring of CQUIN performance targets and the subsequent claiming and recording of earned CQUIN income. We tested the recognition of CQUIN income through the year by confirming the amount of CQUIN income available to the underlying contract challenging on a sample basis the CQUIN income agreed with the commissioners throughout the year and at year end by comparing with internal reporting of performance to confirm consistency between internal and external reporting.
Property valuations The Group holds property assets of £113.5m (2015 £105.8m) within Property, Plant and Equipment at a modern equivalent use valuation. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. The financial statement, at note 12, reflect £0.4m of revaluation gains experienced along with £0.5m of impairments noted and charges to the operating surplus (2015 £2.1m and £1.8m respectively).	•We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. •We used 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 FT ARM, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Laura Mitchell House and New Street brought into use During the year two major capital projects, Laura Mitchell House and New Street, were completed and the assets brought into operational use. Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards and when to commence depreciation. This judgement particularly crystallises at the point when the asset is brought out of assets under construction and into operational use. The value of Laura Mitchell House (£5.3m) and New Street (£3.6m) are included in the transfer from assets under construction of £6.7m disclosed in note 14.1. The impairment of £0.3m disclosed in the same notes includes £0.29m relating to these two assets.	·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 management's review of the value of completed assets transferring out of Assets Under Construction and challenged management's assumptions and judgements concerning whether impairments should be recognised upon bringing the assets into operational use. Where management have used the work of valuations experts in forming their conclusions we have reviewed the work of the expert utilising our valuations specialists. ·We tested the completeness and transparency of the disclosure in the notes to the financial statements.
	The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on 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 £2.27m which is below 1% of revenue and below 2% of Taxpayers' Equity . We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £113,500, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit	Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level. The focus of our audit work was on the Trust, with work performed at the Trust's offices at Castleford and Normanton District Hospital directly by the audit engagement team, led by the audit partner. The Trust's subsidiary the South West Yorkshire Partnership NHS Foundation Trust and Other Charitable funds was subject to an independent examination which in not equivalent to a full audit. The Charity represents less than 0.5% of group operating income and assets employed. We performed specified audit procedures on the Trust's subsidiary, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the charity to the Group. Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group.
	At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems. Data analytic techniques were used as part of audit testing, in particular to support profiling of populations to identify items of audit interest. These techniques were limited to the area of journal testing. All testing was performed by the main audit engagement team, led by the audit partner.

Opinion on other matters prescribed by the National Health Service Act 2006	In our opinion: •the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006, anc •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.

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Paul Thomson, ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK
26 May 2016

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2016

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

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

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

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

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

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

GROUP STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	note	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**	Charity Reserve £000	**Group Total £000**
At 1 April 2015		43,492	16,781	5,220	52,523	118,016	519	118,535
Surplus for the year		0	0	0	441	441	(185)	256
Transfers between reserves		0	(532)	0	532	0	0	0
Impairments	12	0	(30)	0	0	(30)	0	(30)
Revaluations - property, plant and equipment	26	0	3,325	0	0	3,325	0	3,325
Transfer to retained earnings on disposal of assets	26	0	(92)	0	92	0	0	0
Other reserve movements - charitable funds consolidation adjustment		0	0	0	(234)	(234)	234	0
Taxpayers' Equity at 31 March 2016		**43,492**	**19,452**	**5,220**	**53,354**	**121,518**	**568**	**122,086**

		Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**	Charity Reserve £000	**Group Total £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	26	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**

TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	note	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**
At 1 April 2015		43,492	16,781	5,220	52,523	118,016
Surplus for the year		0	0	0	207	207
Transfers between reserves		0	(532)	0	532	0
Impairments	12	0	(30)	0	0	(30)
Revaluations - property, plant and equipment	26	0	3,325	0	0	3,325
Transfer to retained earnings on disposal of assets	26	0	(92)	0	92	0
Taxpayers' Equity at 31 March 2016		**43,492**	**19,452**	**5,220**	**53,354**	**121,518**

		Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**
At 1 April 2014		43,397	14,785	5,220	49,309	112,711
Surplus for the year		0	0	0	3,112	3,112
Revaluations - property, plant and equipment	26	0	2,098	0	0	2,098
Public dividend capital received		95	0	0	0	95
Other reserve movements		0	(102)	0	102	0
Taxpayers' Equity at 31 March 2015		**43,492**	**16,781**	**5,220**	**52,523**	**118,016**

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

Notes to the Accounts - 1. Accounting Policies

1 Accounting Policies

Monitor (the sector regulator for health services in England) is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015 / 2016 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.

These accounts are prepared and presented in GBP in round thousand pounds.

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 31/03/16. A sample 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 valuer. 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 2015 and as a result the revaluation was recognised in these accounts. This has been reviewed as at 31st March 2016 and as there has been no material movement in the indices no further adjustment has been made.

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 2015 / 2016 no key assumptions have been made, or are required, as to future estimation uncertainty further than those already declared in their separate notes.

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 Valuation.

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 2015 / 2016 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 (major capital schemes) completed since 31 March 2015.

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 in carrying value 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 Trust has 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 current value in existing use. When no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. The Trust currently has no intangible assets other than Software licences which 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. The Trust currently has no borrowing costs.

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 1.37% 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 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 2015 / 2016.

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. (see note 25.2)

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 in accordance with the requirements of HM Treasury's FReM.

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.

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 NHS Foundation 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.

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 Financial Reporting Standard (FRS) 102. 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.

Charity Reserve

The Charity Reserve is the balance of funds held by the charity, with both restricted and unrestricted funds. This reserve is used for the furtherance of the objectives of the charity.

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 1 (amendment) disclosure initiative - effective 2016 / 2017
IAS 16 (amendment) and IAS 38 (amendment) depreciation and amortisation - effective 2016 / 2017
IAS 16 (amendment) and IAS 41 (amendment) bearer plants - effective 2016 / 2017
IAS 27 Separate Financial Statements - effective 2016 / 2017
IAS 28 Investments in Associates and Joint Ventures - effective 2016 / 2017
IFRS 9 Financial Instruments - effective 2018 / 2019
IFRS 10 Consolidated Financial Statements - effective 2016 / 2017
IFRS 11 Joint Arrangements - effective 2016 / 2017
IFRS 15 Revenue from contracts with customers - effective 2017 / 2018

The Trust is assessing the impact of these standards and updates.

1.30 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 2016 Total £000**	**Year Ended 31 March 2015 Total £000**
NHS Foundation Trusts	382	362
NHS Trusts	0	0
CCGs and NHS England	193,739	197,073
Local Authorities	16,154	22,611
Department of Health - other	0	0
NHS Other	104	88
Non NHS: Other	2,854	1,093
Total income from activities	**213,233**	**221,227**

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

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

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

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

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

5.5 Operating lease income

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

6 Operating Expenses

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

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

6.2 Other Audit Remuneration	Group & Trust	
	Year Ended 31 March 2016	Year Ended 31 March 2015
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 taxation 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	71	30
Total	**71**	**30**

6.3 Auditor Liability

There is no limitation on the Auditor's Liability in 2015/16 or in 2014/15.

6.4 The late payment of commercial debts (interest) Act 1998

The Group & Trust has no late payments of commercial debts in 2015/16 or in 2014/15.

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 2016			Trust Year Ended 31 March 2016		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	137,532	126,876	10,656	137,566	126,910	10,656
Social Security Costs	9,104	8,299	805	9,104	8,299	805
Pension costs - defined contribution plans employers contributions to NHS Pensions	16,549	15,714	835	16,549	15,714	835
Termination benefits	3,123	3,123	0	3,123	3,123	0
Agency/contract staff	8,419	0	8,419	8,419	0	8,419
NHS charitable funds staff	34	34	0	0	0	0
Employee benefits expense	**174,761**	**154,046**	**20,715**	**174,761**	**154,046**	**20,715**
Of which are capitalised as part of assets	317	317	0	317	317	0
Total Employee benefits excl. capitalised costs	**174,444**	**153,729**	**20,715**	**174,444**	**153,729**	**20,715**

	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**

The Board has approved a cost saving programme which resulted in 32 posts being made redundant in 2015/16. The Trust has an identified a cost saving programme for 2016/17 and the impact of this includes the potential redundancy impact of 142 posts and a further in 51 relating to 2017/18. The total redundancy cost provided for in 2015/16 is£6,820k (£5,175k in 2014/15). (See note 24)

As included within the salaries and wages information above, the Trust made payments in 2016/17 of greater than £100k to the following staff groups:

	Year Ended 31 March 2016	Year Ended 31 March 2015
Medical Consultant	60	57
Middle Grade Doctor	5	8
Director / Chief Executive	7	8
Total	**72**	**73**

7. Employee costs and numbers (continued)

7.2 Average number of people employed

	Group			Trust		
	Year Ended 31 March 2016			Year Ended 31 March 2016		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	154	123	31	154	123	31
Administration and estates	890	822	68	888	820	68
Healthcare assistants and other support staff	1,015	977	38	1,015	977	38
Nursing, midwifery and health visiting staff	1,366	1,344	22	1,366	1,344	22
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	663	631	32	663	631	32
Social care staff	0	0	0	0	0	0
Agency and Contract staff	102	0	102	102	0	102
Bank Staff	218	0	218	218	0	218
Other	0	0	0	0	0	0
Total	**4,408**	**3,897**	**511**	**4,406**	**3,895**	**511**
Of which are engaged on capital projects	**6**	**6**	**0**	**6**	**6**	**0**

	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	162	131	31
Administration and estates	917	848	69	916	848	68
Healthcare assistants and other support staff	1,048	1,011	37	1,048	1,011	37
Nursing, midwifery and health visiting staff	1,420	1,393	27	1,420	1,393	27
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	684	652	32	684	652	32
Social care staff	0	0	0	0	0	0
Agency and Contract staff	60	0	60	60	0	60
Bank Staff	153	0	153	153	0	153
Other	0	0	0	0	0	0
Total	**4,444**	**4,035**	**409**	**4,443**	**4,035**	**408**
Of which are engaged on capital projects	**3**	**3**	**0**	**3**	**3**	**0**

Unit of measure is whole time equivalent (WTE).

The Trust wte numbers for the year ended 31st March 2015 have been restated. The previous totals were 4638, 4205 and 433 respectively. This was required to ensure that the final wte for 2015 / 2016 are shown to allow a accurate comparison.

7.3 Staff sickness absence

	Group & Trust	
	Year Ended 31 March 2016	Year Ended 31 March 2015
	Number	Number
Total days lost	46,852	45,352
Total staff years	4,129	4,235
Average working days lost	11.3	10.7

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 2015-16 January 2015 - December 2015.

7.4 Early retirements due to ill health

During the year there were 6 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health (7 during 2014/15). The estimated additional pension liabilities of these ill-health retirements is £337k (2014/15 £670k). 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

32 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 2016

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	7	29	22	80	**29**	**109**
£10,001 - £25,000	8	124	1	11	**9**	**135**
£25,001 - £50,000	6	215	0	0	**6**	**215**
£50,001 - £100,000	7	545	0	0	**7**	**545**
£100,001 - £150,000	2	248	0	0	**2**	**248**
£150,001 - £200,000	2	317	0	0	**2**	**317**
Total number of exit packages by type	**32**	**1,478**	**23**	**91**	**55**	**1,569**

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 23 contractual payments made to individuals in lieu of notice. (20 in 2014/15)

Exit Packages: other (non-compulsory) departure payments	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	31 March 2016	31 March 2016	31 March 2015	31 March 2015
	Number	£'000	Number	£'000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	23	91	20	70
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-Contractual payments requiring HMT approval	0	0	0	0
Total	**23**	**91**	**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	0	0

8. Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are 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. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in each scheme is taken as equal to the contributions payable to that 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 (currently the Government Actuary's Department) 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 2016, is based on the valuation data as at 31 March 2015, updated to 31 March 2016 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) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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:

From 1 April 2015 there are two separate pension schemes covering NHS workers, the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme.

The 2015 NHS Pension Scheme, effective 1 April 2015, is a "Career Average Revalued Earnings" (CARE) scheme. From the above date, annual pensions are normally based on 1/54th of a member's CARE for each year of service. CARE is defined as a member's average earnings in a financial year, and is uplifted annually by a percentage determined by the Treasury. Members who are practitioners as defined by the Scheme Regulations are subject to exactly the same arrangements as all members who are directly employed by the NHS, with effect from the above date.

The 1995/2008 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 35 lease properties, all with different Landlords. The rental periods range from 1 to 21 years. 7 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 2016 £000**	**Year Ended 31 March 2015 £000**
Minimum lease payments	6,747	7,026
	6,747	**7,026**

Future minimum lease payments due	**Year Ended 31 March 2016 £000**	**Year Ended 31 March 2015 £000**
Payable:		
Not later than one year	5,198	4,729
Between one and five years	14,069	11,289
After five years	23,195	22,904
Total	**42,462**	**38,922**

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

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

11. Finance Costs - interest expense

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

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

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

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

13 Intangible assets

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

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

13.3 Intangible assets

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

14.1 Property, plant and equipment 31 March 2016

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

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

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

14.2 Property, plant and equipment 31 March 2015

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

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

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

14.3 Economic Lives of Property, Plant and Equipment

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

14.4 Finance Leases

The Group & Trust hold no finance lease assets.

15 Investments

15.1 Investments - Carrying Value

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

* The Group & Trust has no other investments.

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

15.2 Investment Property expenses

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

15.3 Investments in subsidiaries

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

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

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

Summary Statement of Financial Activities

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

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

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

16.1 Non-current assets held for sale

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

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

16.2 Liabilities in disposal groups

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

17. Other assets

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

18. Other Financial Assets

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

19. Inventories

19.1. Inventory Movements

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

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

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

20. Trade and other receivables

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

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

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

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

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

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

20.4 Finance lease receivables

The Group & Trust has no finance lease receivables.

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

Third party assets (Patient Monies) held by the Trust

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

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

22. Trade and other payables

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

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

22.2 Better Payment Practice Code

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

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

22.3 Early retirements detail included in NHS payables

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

22.4 Other liabilities

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

22.5 Other Financial Liabilities

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

23. Borrowings

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

24. Provisions

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

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

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

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

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

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

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

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

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

25. Contingencies

25.1 Contingent liabilities

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

25.2 Contingent assets

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

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

26. Revaluation reserve

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

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

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

27. Finance lease obligations

The Group & Trust had no finance lease obligations.

28. Finance lease commitments

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

29. Capital commitments

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

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

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

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 2016)	**7,336**	7,336	**7,339**	7,339
Cash and cash equivalents (at bank and in hand at 31 March 2016)	**27,107**	27,107	**27,107**	27,107
NHS Charitable funds: financial assets (at 31 March 2016)	**586**	586	**0**	0
Total at 31 March 2016	**35,029**	**35,029**	**34,446**	**34,446**
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**

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 2016)	**19,272**	19,272	**19,272**	19,272
Provisions under contract (at 31 March 2016)	**10,017**	10,017	**10,017**	10,017
NHS Charitable funds: financial liabilities (at 31 March 2016)	**15**	15	**0**	0
Total at 31 March 2016	**29,304**	**29,304**	**29,289**	**29,289**
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**

30.3 Maturity of Financial liabilities

	Group 31 March 2016 £000	Group 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
In one year or less	24,369	24,359	24,354	24,358
In more than one year but not more than two years	2,642	2,968	2,642	2,968
In more than two years but not more than five years	1,292	325	1,292	325
In more than five years (see note 24)	1,001	1,030	1,001	1,030
Total	**29,304**	**28,682**	**29,289**	**28,681**

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 2016 are in income 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. Trustee and Treasurer, Spectrum People, Trustee, NHS Confederation, Chair, Huddersfield University Business School Advisory Board, Chair, NHS Confederation Mental Health Network, member of Health & Wellbeing Boards, Wakefield and Barnsley (to 31 March 2016), Involvement in Care Quality Commission mental health inspection arrangements (to 31 March 2016), and partner, NHS Interim Management and Support (to 31 March 2016) employed by Mid Yorkshire Hospitals NHS Trust. Huddersfield University provided services to the Trust in 2015/16 to the value of £95,054 (2014/15 £30,487).

Ian Black, Chair of the Trust is a Non-Executive Director of Benenden Healthcare Society, Chair Benenden Wellbeing, Non-Executive Director,Seedrs (with small shareholding), Chair, Family Fund, Chair, Keegan and Pennykidd (insurance brokers), Trustee and Director, NHS Providers, 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.

Jonathan Jones, Non Executive Director is a Member, Squires Patton Boggs (UK) LLP and Squire Patton Boggs MENA LLP and a Trustee, Hollybank Trust. Spouse is Company Secretary and a shareholder in Zenith Leasedrive Holdings Limited.

Laurence Campbell, Non Executive Director is Trustee and Treasurer, Kirklees Citizen's Advice Bureau and Law Centre,

Rachel Court, Non Executive Director is Director, Leek United Building Society, Director, Invesco Perpetual Life Ltd., Chair, PRISM, Governor Calderdale College, Magistrate and Chair, NHS Pension Board.

Charlotte Dyson, Non Executive Director is Independent marketing consultant, Beyondmc (marketing consultancy work for Royal College of Surgeons, Edinburgh), Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional), Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee, Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee and Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.

Julie Fox, Non Executive Director is Trustee and Advisory Board member, Peer Power (social justice organisation supporting young people), employed by HM Inspectorate of Probation (to 30 June 2016) and daughter appointed as Independent Hospital Manager.

Christopher Jones, Non Executive Director is Director and part owner, Chris Jones Consultancy Ltd and Trustee, Children's Food Trust.

Dawn Stephenson, Director of Corporate Development is a voluntary Trustee for Kirklees Active Leisure and Governor, Membership Council, Calderdale and Huddersfield NHS Foundation Trust (and member of Remuneration and Terms of Service sub-committee)

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 2015/16 to the value of £179,977 (2014/15 £232,421).

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 2015/16 to the value of £172,843 (2014/15 £36,433).

34.1 Related Party Transactions

	Group & Trust	
	Income	**Expenditure**
	£000	**£000**
Value of transactions with other related parties in 2015/16		
Department of Health	0	28
Other NHS Bodies	200,703	10,529
Other		
Total	**200,703**	**10,557**

	Income	**Expenditure**
Value of transactions with other related parties in 2014/15	**£000**	**£000**
Department of Health	20	91
Other NHS Bodies	204,275	15,576
Other	0	0
Total	**204,295**	**15,667**

34.2 Related Party Balances

	Group & Trust	
	Receivables	**Payables**
	£000	**£000**
Value of transactions with other related parties in 2015/16		
Department of Health	0	23
Other NHS Bodies	2,522	2,328
Other		
Total	**2,522**	**2,351**

	Receivables	**Payables**
Value of transactions with other related parties in 2014/15	**£000**	**£000**
Department of Health	0	46
Other NHS Bodies	4,170	2,467
Other	0	0
Total	**4,170**	**2,513**

35. Losses and Special Payments

	Group & Trust			
	Year Ended 31 March 2016 Total number of cases Numbers	Year Ended 31 March 2016 Total value of cases £000s	Year Ended 31 March 2015 Total number of cases Numbers	Year Ended 31 March 2015 Total value of cases £000s
Losses:				
1. Losses of cash due to:				
a. theft, fraud etc	1	0	0	0
b. overpayment of salaries etc	0	0	0	0
c. other causes	4	0	1	0
2. Fruitless payments and constructive losses	1	500	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	**6**	**500**	**1**	**0**
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	37	4	36	4
d. other negligence and injury	4	1	0	0
8. Special severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0
Total Special Payments	**41**	**5**	**36**	**4**
Total Losses and Special Payments	**47**	**505**	**37**	**4**

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 has been no fruitless payments where the net payment exceeded £300,000. The Trust has provided £500,000 in relation to a potential penalty for Information Governance breaches

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 2015/16 were:
Ian Black (Chair of the Committee, Chair of the Trust), Jonathan Jones (Non-Executive Director of the Trust), Helen Wollaston (to July 2015) (Non-Executive Director of the Trust), Rachel Court (from October 2015) (Non-Executive Director), Steven Michael (Chief Executive) (non-voting member) 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	31/03/2016						
	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	13.0			1.5		55 - 60
Peter Aspinall, Non-Executive Director (left 30/04/15)	0 - 5				0.4		0 - 5
Jonathan Jones, Non-Executive Director	10 - 15						10 - 15
Helen Wollaston , Non-Executive Director (left 31/07/15)	5 - 10				1.5		5 - 10
Julie Fox, Non-Executive Director	15 - 20				1.3		15 - 20
Laurence Campbell, Non-Executive Director	15 - 20				0.6		15 - 20
Charlotte Dyson, Non-Executive Director (from 01/05/15)	10 - 15				1.2		10 - 15
Rachel Court, Non-Executive Director (from 01/10/15)	5 - 10				0.6		5 - 10
Christopher Jones, Non-Executive Director (from 01/08/15)	5 - 10				0.4		5 - 10
Steven Peter Michael, Chief Executive (left 31/03/16)	170 - 175	2.2	10 - 15		0.7	0	185 - 190
Alan George Davis, Director of Human Resources and Workforce Development	105 - 110	1.5	5 - 10			0	115 - 120
Alexandra Farrell, Deputy Chief Executive (and Director of Finance to 31/12/15)	120 - 125		5 - 10		0.3	0	130 - 135
Dawn Stephenson, Director of Corporate Development	80 - 85	23.3	5 - 10		0.7	0	110 - 115
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	105 - 110	1.0	5 - 10		0.2	2.5 - 5.0	120 - 125
Adrian Berry, Medical Director	35 - 40	2.9		115 - 120	1.1	195.0 - 197.5	350 - 355
Sean Rayner, District Service Director, Barnsley and Wakefield	100 - 105		5 - 10			0	105 - 110
Karen Taylor, District Service Director, Calderdale and Kirklees	95 - 100		5 - 10		1.3	0	105 - 110
Nette Carder, Interim District Director, CAMHS and forensic services (left 25/03/16)	170 - 175						170 - 175
Diane Smith, Director of Service Innovation and Health Intelligence	90 - 95		5 - 10		0.7	12.5 - 15.0	110 - 115
Carol Harris, Director of Forensic and Specialist Services (from 21/03/16)	0 - 5					2.5 - 5.0	5 - 10
Kate Henry, Interim Director of Marketing, Engagement and Commercial Development (from 05/05/15)	85 - 90						85 - 90
Jon Cooke, Interim Director of Finance (from 04/01/16)	35 - 40						35 - 40

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	0	95 - 100
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	0	105 - 110
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	95 - 100		0 - 5		1.4	0	100 - 105
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					0	20 - 25

	31/03/2016	31/03/2015
Band of Highest Paid Director's Total Remuneration (£000's)	185 - 190	170 - 175
Median Total Remuneration* £'s	27,840	27,306
Remuneration Ratio	6.7	6.4

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
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

Where the calculation in the Pension Related Benefits results in a negative number, a zero is substituted, this is in line with SI 2013, No 1981 - The Large and Medium sized-Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013. Negatives were previously shown in 2014/15 for Dawn Stephenson, Sean Rayner, Karen Taylor and Diane Smith, these have been restated to zero.

The Trust operates a Performance Related Pay scheme (PRP) for Directors. The scheme in 2015/16, which is non-attributable and non-pensionable and has a maximum value of 10%, provides for a maximum award of 5% for achieving all four Gateway Objectives and discretion for the Remuneration and Terms of Service Committee to award 2% where 3 out of the 4 are achieved or to award 1% where 2 out of the 4 are achieved. In 2015/16, for any performance award to be made, the Trust must receive a rating of 'good' or 'outstanding' from its Care Quality Commission inspection (undertaken in March 2016), which is part of the gateway covering effective governance, maintaining compliance and service qual Also, 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 individual Director performance and approved by the Remuneration and Terms of Service Committee to a maximum of 5%. In 2015/16, 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 2015/16 the accounts include £83k accrual as an estimate for the award of PRP which related to 2015/16 performance. The PRP award will be proposed by the Chief Executive and will be approved by the Remuneration and Terms of Service Committee in 2016/17. This will be disclosed in detail in the remuneration report in the 2016/17 accounts.

The Annual Performance Related pay in 2015 / 2016, disclosed in the table above, relates to payments made in 2015 / 2016 for performance in 2014 / 2015 which was approved by the Remuneration and terms of service Committee in 2015 / 2016.

Other remuneration for 2015/16 relates to payment for substantive clinical posts held within the Trust.

Expenses for 2015/16 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).

* 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.

Signed……
Rob Webster Chief Executive Date 23 May 2016

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 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £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 (left 31/03/16)	60	0 - 5	260 - 265	1,272	1,223	16	0
Alan George Davis, Director of Human Resources and Workforce Development	60	0 - 5	195 - 200	1,029	987	16	0
Alexandra Farrell, Deputy Chief Executive (and Director of Finance to 31/12/15)	60	0 - 5	145 - 150	727	689	19	0
Timothy Breedon, Director of Nursing, Clinical Governance and Safety	65	(0 - 5)	85 - 90	540	506	21	0
Adrian Berry, Medical Director	55	35 - 40	270 - 275	1,273	1,060	184	0
Dawn Stephenson, Director of Corporate Development	60	(10 - 15)	140 - 145	721	746	(45)	0
Sean Rayner, District Service Director, Barnsley and Wakefield	60	0 - 5	150 - 155	709	681	10	0
Karen Taylor, District Service Director, Calderdale, Kirklees and specialist services	55	0 - 5	170 - 175	818	786	11	0
Diane Smith, Director of Service Innovation and Health Intelligence	60	0 - 5	140 - 145	774	721	33	0
Carol Harris, Director of Forensic and Specialist Services (from 21/03/16)	60	0 - 5	120 - 125	536	453	71	0
Jon Cooke, Interim Director of Finance	60	(0 -5)	130 - 135	534	525	(5)	0

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform the calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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.

Signed…… ……

Rob Webster Chief Executive Date 23 May 2016