NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Annual Report and Accounts

for the period 1 April 2017 to 31 March 2018

With **all of us** in mind.

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE PERIOD 1 APRIL 2017 TO 31 MARCH 2018

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

Message from the Chair and Lead Governor 2017/18

Welcome to the Trust's annual report for the year 1 April 2017 to 31 March 2018.

We knew 2017/18 would be a tough year and our values would remain our guide. Whether reassuring us that we're doing the right thing, or inspiring us to keep our heads up when faced with challenges, we are proud to work somewhere where our values are more than something written on the wall. We live them every day and rely on them when times are good and bad.

Visits from the Care Quality Commission (CQC) recognised this and saw an organisation that genuinely will listen – one that wants to improve and be outstanding and keeps the person firmly in the centre. "We saw an open, transparent culture that was centred on people," they wrote in their informal summary of their latest inspection of the Trust, which took place from February to April 2018.

Amongst their highlights, they found that people smiled and engaged in discussions without being defensive. We were proud to receive praise for our strengths and humble enough to gracefully accept the need to continuously make improvements. It's this culture that's so deeply embedded in our organisation that has helped us to achieve so many things this year. Some highlights include:

- We were chosen as the 'best organisation' in the 2017 Kate Granger awards for compassionate care, honouring the late #hellomynameis doctor. Judges recognised our ambitious and innovative way of delivering care which makes a long-term, measurable difference to people's lives.
- We were one of eight organisations to have been awarded the Wakefield Wellbeing Charter Mark for our commitment to the health and wellbeing of our staff.
- We retained 'compliance plus' accreditation in our Customer Service Excellence report, where we were assessed on our organisational performance which includes customer insight, culture, and quality of service. The assessor described staff he met as "passionate, committed and focused".
- All three of our adult acute mental health wards at Fieldhead Hospital in Wakefield were accredited by The Royal College of Psychiatrists.
- The work of staff at our Stroke Rehabilitation Unit in Barnsley was highlighted as best practice by the Royal College of Physicians.
- We were highlighted as an example of how to improve mental health services in a publication by the Care Quality Commission (CQC).
- We were successful in attracting over £200,000 worth of funding to help us manage the pressures that often arise during the winter months.

We can't ignore the fact that this has been a challenging year across the health and care sector with lots going on in our external environment. One of the worst flu seasons in history saw incredible pressures put on us and our acute hospital colleagues and partners, but we worked together to meet our target for vaccinating our frontline staff against flu.

There are still some things we need to take with us into 2018/19 and maintain a focus on. These include our use of out of area bed placements, continuing to manage service change and further developing the way we work in the health systems in which we operate. We've already put a huge amount of effort into some very challenging issues like out of area bed placements. We're trying to manage the pressure and will ensure that we care for people in their local communities whenever possible. When we're faced with issues like this, our staff remain admirably resilient and make sure that the people who use our services are kept firmly at the centre of everything we do.

The next year will also see us continue to focus on how we support our workforce and maintain sight on the wellbeing of our staff, as we can only provide the best care for people if we are caring for ourselves too. The launch of our #allofus campaign, promoting staff wellbeing, contributed to our staff rating us as above average for feeling that we take positive action on health and wellbeing in the 2017 NHS Staff Survey.

Through improving the wellbeing of our staff we can also improve the quality of our care. Our #allofusimprove campaign saw a light shone on the changes our staff and teams have made across three key areas: patient safety, operational excellence, and experience of care. Looking back at the year, we've seen lots of stress, pressure and challenges, but at the same time lots to reflect on and celebrate.

Our Excellence awards were a chance to recognise our staff for their tireless commitment, dedication, care and compassion in making a difference to the lives of local people. In November 2017 over 200 people including our staff, partners, Board, members' council and generous sponsors joined us to celebrate all 175 entrants. It was a hugely successful, emotional, memorable night and a tribute and testimony to the hard work every one of our staff commits to this organisation every day.

We also see unrivalled commitment and dedication from our volunteers. We have over 200 volunteers representing a fantastic contribution of 773 hours per week - that's 37,808 hours over the year. We have a variety of volunteer roles across our services and have committed to an additional 70 roles to mark the 70th birthday of the NHS.

The NHS will celebrate its 70th birthday on 5 July 2018. In the run up to the day we've seen some brilliant celebrations of all the things our health service – and the people within it – have achieved throughout the years. There have been awards, tea parties, fun runs – and not forgetting our own NHS70 Superstar recognition scheme. Almost 1,500 of our staff have received praise from a colleague, service user or member of the public for everything from running a ward with efficiency and skill to being there with a cup of tea when times were tough.

Our black, Asian and minority ethnic (BAME) network also celebrated a milestone birthday when they looked back on one year since the staff group was established. An event to mark the occasion featured guest speaker Dr Habib Naqvi, NHS England's deputy workforce race equality policy lead. It focused on progress made since the creation of the network, including those seen in the NHS workforce race equality standard. Equality and diversity in our workforce is a big priority for our organisation and something we're going to be focusing on in the year ahead.

This year we've seen significant investment in our buildings, which will continue into the next year. New adult mental health wards at Fieldhead in Wakefield opened in September 2017. Our Unity Centre has been purpose built and treats people from across our region, and two wards are now open as well as a new place of safety for people in crisis. The next phase of the development is now underway as part of our £17m investment. The work is completely transforming our facilities and the care we're able to provide.

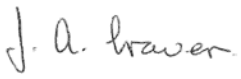
It's been a great year for our recovery colleges, who have had another successful 12 months of busy courses and learning opportunities. Our recovery colleges are all about equipping people with the skills and knowledge to take part in self-care, putting them in control of their own recovery and enabling them to develop their strengths. Courses are developed and delivered by people with experience of health problems, alongside people with professional experience, showcasing our commitment to co-production.

Our linked charities have also been able to look back at a year of fantastic achievements – however, some of them now look a little different to what they did in 2016. We re-launched and re-branded our charity, EyUp!, which supports the work of our Trust. It helps bring health and happiness to Yorkshire folk, adding flourishes to services. Many of our staff got on board with our Trustwide team challenge to raise money to support our service users. Along with our other linked charities – Creative Minds, Spirit in Mind and the Mental Health Museum – they can look back on 2017/18 with pride.

We must reflect on what a positive year it was. We should be confident going into the next year as we know that when demanding times hit, we still deliver. As the NHS faced one of its hardest years ever, our organisation improved its quality, delivered on its finances, saw an increase in staff saying they feel connected, lived its values, won new business and awards, and maintained its focus. We also supported staff where services were decommissioned, significantly changed, or transferred to other providers.

We need to reflect on what we've achieved in challenging times – and it's a lot – and it's no doubt down to the constant commitment, dedication and hard work of our staff and volunteers. Thank you.

Angela Monaghan
Chair



Jackie Craven
Lead Governor

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Section 1 – Performance Report

Section 1.1 Overview of performance

Purpose and statement from CE on their perspective on the performance in 2017/18 Review of 2017/18 – Chief Executive Reflections

Section 1 of this report reflects a challenging and successful year for the Trust. 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, staffing, performance and the achievement of our financial control total. I would highlight:

We lived our mission and values

We exist to help people to reach their potential and live well in their community, and 2017/18 was no exception. Our values are important to us, and are frequently cited as a strength of ours, for example by the Care Quality Commission (CQC). We focused further on these, and co-produced a set of Trust behaviours, which show how we live our values in day-to-day practice.

We also developed a new film featuring our staff and service users that brings our values and philosophy to life. Watch 'with all of us in mind' at: www.youtube.com/swypft.

We delivered safe care and achieved key targets

We put safety first, always. In 2017/18, we welcomed the CQC back to give their independent view on the safety of our services. In December 2017 they inspected Ward 18 at the Priestley Unit in Dewsbury and found that care was safe, in line with our overall 'Good' rating. Then, from February - April 2018, the CQC undertook our latest re-inspection, visiting a wide range of services, as well as carrying out a well-led review. Our results will be published in summer 2018.

We kept a strong focus on incident reporting and investigations, with more than 12,300 incidents reported during the year. The majority of these resulted in low or no harm, reflective of a positive safety and reporting culture.

We achieved targets set by our regulators and commissioners. These included access to key services, such as early intervention in psychosis and improving access to psychological therapies. We also achieved our own internally-set targets, including:

- 73% of staff vaccinated against flu
- 97% of staff having an appraisal
- 85% of staff trained in the Mental Health Act
- 90% of staff trained in the Mental Capacity Act.

We embraced change and tackled challenges

- Challenging winter - It was an extremely demanding winter across the NHS and social care. We all pulled together to continue caring for local people. This was supported by extra winter pressures funding, which was used to boost liaison teams in accident and emergency departments and to support discharge from our mental health wards.
- Out of area placements - The number of people needing to travel out of area in 2017/18 increased significantly. This affects the quality of care as well as being more costly. We focused our efforts on addressing this, improving internal processes and working with external partners.
- Service changes - Some of our services have seen big changes with decommissioning, new contracts and models of care. Some staff have transferred to other NHS organisations and others have moved base or now work in the community. Throughout this, staff have been extremely resilient; always keeping service users at the forefront of all decisions.
- Collaborative working - We continued to play a key role in regional and local developments. This included the West Yorkshire and Harrogate Health and Care Partnership and the South Yorkshire and Bassetlaw integrated care system. We continued working in partnership with mental health providers across West Yorkshire, including playing a lead role in suicide prevention, forensic mental health, and learning disabilities.
- New Trust Board members - We welcomed two new non-executive directors in August 2017, Kate Quail and Angela Monaghan. In November, Angela became Chair of the Trust following the departure of Ian Black. Charlotte Dyson became our Deputy Chair / Senior Independent Director, replacing Julie Fox. I would particularly like to thank Ian and Julie for their vast contribution to the Trust and welcome Angela and Kate to our Trust Board. Our esteemed medical director, Dr Adrian Berry, announced plans to retire in April 2018 and we appointed Dr Subha Thiyagesh in his place.

We remained focused on risk

Our approach to risk has ensured a focus on appropriate risk appetite for different issues. We have been very strong on clinical risk, with a low risk appetite helping to drive a safety culture. Our approach to risk has received significant assurance. Alongside this, the Board has ensured strategic risks and opportunities have been reviewed regularly by the whole Board.

Our major developments got us ready for tomorrow

- New adult mental health wards at Fieldhead Hospital in Wakefield opened in September 2017. Our Unity Centre has been purpose-built and treats people from across our region. Two wards are now open, as well as a new place of safety for people in crisis. The next phase of the development is now underway as part of our £17m investment.

- Our wellbeing and learning centre was refurbished to bring it up to date and provide a more flexible use of the space, including agile working areas. The area now houses a dedicated staff wellbeing room as well as displaying service user artwork.
- We were chosen as an early adopter for NHS Wi-Fi, a national scheme to roll out free Wi-Fi for service users and the public.
- We launched a new programme to replace our mental health clinical record system. The system, SystmOne, is being co-designed with our staff.
- We opened a new volunteer lounge which includes an IT room, meeting space and lounge area.
- We re-launched our charity EyUp! which supports the work of our Trust. It helps bring health and happiness to Yorkshire folk, adding flourishes to services.

We continued to become a better place to work
We launched a major staff wellbeing campaign called #allofus – focusing on key areas of flu, musculoskeletal issues, stress and lived experience. Our 2017 NHS Staff Survey results, published in March 2018, showed we're above average for staff feeling that we take positive action on health and wellbeing. Over 1,900 staff took part in the survey, which showed some great improvements, alongside areas we need to focus on. The results are being addressed in our workforce strategy action plan.

We made continued improvements in how we communicate and engage with staff. In December 2017, 88% of staff said they felt kept up to date with what is happening across the Trust. This is compared to 83% in 2016 and 57% in 2015. Staff feeling satisfied with the way the Trust communicates and engages with them also improved – up 31% over the past two years, from 45% to 76%.

At the end of March 2018, we had 206 volunteers – representing a fantastic contribution of 773 hours per week - that's 37808 hours over the year. We have a variety of volunteer roles across our services and have committed to an additional 70 roles to mark the 70th birthday of the NHS.

To celebrate the NHS turning 70, we launched our NHS70 superstar scheme. It's a way to recognise and thank our staff for helping us achieve our mission and for living our values each and every day. By the end of March we had received more than 1,000 nominations. Be inspired by the nominations at: www.southwestyorkshire.nhs.uk/superstar.

We held an event to celebrate learning and long service. Staff who have completed additional learning within their roles were recognised, as well as those who have contributed 25 or 40 years of service to the NHS.

Our black, Asian and minority ethnic (BAME) staff network celebrated its one year anniversary. An event to mark the occasion featured guest speaker Dr Habib Naqvi, NHS England's deputy workforce race equality policy lead. It focused on progress made since the creation of the network, including those seen in the NHS workforce race equality standard. The development of two further staff networks also got underway – a disability network and a lesbian, gay, bisexual, and trans (LGBT) network.

We all played our part and achieved our financial plan
A surplus of £1.1m was narrowly achieved to meet our control total. This was due to the efforts of everyone in the Trust. We also had one-off benefits, for example, from an insurance payment of £0.5m which partly covered the loss of bed capacity from the impact of a fire in 2016 and sale of properties (£0.4m).

We reduced our discretionary and non-pay spend substantially and agency spend fell by 41% compared to 2016/17. We made £7.5m of cost improvement savings and we also received the vast majority of income from achieving quality standards set by our commissioners, known as CQUINs.

We secured an extra £1.5m from NHS Improvement's Sustainability and Transformation Fund. This is in addition to £1.4m that we had planned for.

We won a number of bids and tenders and worked in partnership, moving towards a broader, system-wide role for many services. We also supported staff where services were decommissioned, significantly changed, or transferred to other providers.

Our underlying financial position was a small deficit when all one-off measures were taken into account.

We celebrated excellence

Our Excellence awards, held in November 2017, highlighted individuals and teams right across the organisation that had demonstrably lived our mission and values. The NHS is made of people, not buildings and kit, and the Excellence awards were a real highlight of the year in recognising the contribution of many in achieving our objectives. More than 200 people, including our staff, partners, members' council and generous sponsors, joined us to celebrate all 175 entrants. View all our winners at: www.southwestyorkshire.nhs.uk.

We showcased our work and won awards

- We were chosen as the 'best organisation' in the 2017 Kate Granger awards for compassionate care. Judges recognised our ambitious and innovative way of delivering care which makes a long-term, measurable difference to people's lives.
- Creative Minds was named organisation of the year at Disability Sport Yorkshire's awards 2018.
- We were highlighted as an example of how to improve mental health services in a new publication by the Care Quality Commission (CQC).
- Along with our partners, NHS England and Leeds Community Healthcare NHS Trust, we won a Nursing Times award in the child and adolescent services category.
- A new social prescribing assessment tool, created by our Live Well Wakefield service in partnership with West Wakefield Health & Wellbeing Ltd, was endorsed by the National Institute for Health and Care Excellence (NICE).
- Our community mental health team for older people in Pontefract were named Top Team and Champions of Change by Wakefield Council.
- We held our first major spirituality conference in June: Faith communities and mental health – Spirit in Mind.

Some things will need continuing focus in 2018/19

We are not complacent and we know that 2018/19 will be an increasingly challenging year. We need to keep a strong focus on:

- Addressing workforce pressures – our staff survey results show more needs to be done on a number of issues, including tackling work place stress. We also need to ensure we can recruit and retain enough staff.
- Acuity and demand for services is rising beyond capacity in some services – we are working with commissioners and provider partners to ensure we can continue to deliver good care.
- Financial sustainability – with efficiency requirements at high levels in an environment of reducing income.
- Out of area placements – which reached record levels at the end of 2017/18.

At the same time, we must focus our efforts on quality improvement, and our new campaign #allofusimprove will help to empower people to take action where they see something that can be improved. We are concentrating on patient safety, experience of care, and operational excellence.

This whole report is a testament to the staff who work here and what they do each and every day.

Brief history of the Trust

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 services to the Trust in Barnsley, Calderdale and Wakefield.

Purpose and activities

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 13,000 local people (including our staff) are currently members.

The Trust now employs around 4,100 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 approximately 45,000 mental health and learning disability contacts and 36,000 community health service contacts.

Our vision, mission, values and strategic goals

There are four clearly identified strategic ambitions which the Board has agreed and are summarised as:

- **Regional centre of excellence** for Specialist and Forensic Mental Health and Learning Disability services.
- **A strong partner in Mental Health service provision** across West Yorkshire (West Yorkshire & Harrogate Health and Care Partnership) and South Yorkshire (South Yorkshire & Bassetlaw Shadow Integrated Care System).
- **A host or partner in four local integrated care partnerships (accountable care organisations (ACOs))** - Barnsley, Calderdale, Kirklees and Wakefield.
- **An innovative organisation with coproduction at its heart**, building on Creative Minds, Recovery Colleges, Mental Health Museum and Altogether Better.

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.

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

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.

Our three strategic objectives for 2017/18 were:

1. Improving health
2. Improving care
3. Improving resources

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.

Key issue and risks

The key risks that impact on the Trust in the delivery of its objectives are set out in detail in the Annual Governance Statement. The Board Assurance Framework, Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Boards risk appetite statement. Other key issues identified through the quarterly Board Investment appraisal reports and PESTLE (Political, Economic, Sociological, Technological, Legal, Environmental) and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis are set out below:

We identified: Staff health & wellbeing concerns in a changing and demanding environment.
We acted: We have improved our staff health & wellbeing offer to include access to a range of services and developed a trust-wide approach to supporting staff health & wellbeing.

We identified: A risk that funding for mental health services would not be in line with that identified in the Five Year Forward View.
We acted: We worked with our commissioners to agree mental health investment priorities and to secure funding for those investments.

We identified: Clinical record system resilience and suitability for current clinical practice was a risk.
We acted: We are implementing a new clinical record system which is being co-designed with clinical staff for implementation in early 2019.

We identified: The lack of access to wi-fi in our facilities was not meeting service user needs.
We acted: We were successful in an application for national monies and have implemented wi-fi across many of our facilities.

Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the Trust has 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.

In making this assertion the Trust Board has taken a number of factors into account. The Trust has updated its financial plan for 2018/19, which was approved by the Trust Board and submitted to NHS Improvement for review. As part of the plan preparation and approval process the Trust Board has considered in detail the Trust's position, reviewing the financial viability of the organisation in the challenging economic climate.

Section 1.2 Performance analysis

Our performance

In addition to measuring performance against our quality priorities we monitor our performance against a range of other key performance indicators (KPIs). A number of these are reported to our Trust Board and others are reported and acted upon internally. A range of performance data is also shared with our commissioners. For 2017/18, the Trust identified those metrics that would best demonstrate performance against achievement of its agreed objectives. These are reported to the Trust Board as part of the Integrated Performance Report (IPR) every month. The KPIs represent a mix of nationally and locally set targets.

Improve people's health and reduce inequalities		
KPI	**Target**	**Year-End Performance**
Total number of children & younger people in adult in patient wards	0	3
% service users followed up within 7 days of discharge	95%	95.8%
% clients in settled accommodation	60%	78.8%
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks(as at Quarter 3)		86.8%
Out of area beds (days)	1,200	5,044
Improving Access to Psychological Therapies (IAPT) – proportion of people completing treatment and moving to recovery	50%	56.5%

At the end of the year we achieved all the KPIs set by our regulator, NHS Improvement, with the exception of the number of service users on CPA in employment. This is encouraging given increases in demand for our services and the level of pressure across the system. Achievement of these NHS Improvement metrics reflects very positively on our staff and the focus we place on ensuring we meet the high standards expected from our services.

The issue of out of area bed placements is explained more fully in other sections of this report on pages 21, 23 and 31, but the Trust strives to keep the use of such placements to an absolute minimum. Demand for beds was such that we did not achieve our target.

Improve the quality and experience of care		
KPI	**Target**	**Year-End Performance**
Friends and Family Test – Mental Health	85%	87%
Friends and Family Test - Community	98%	99%
Patient safety incidents involving moderate or severe harm or death	-	31
Safer staff fill rates	90%	115.7%
Information Governance confidentiality breaches	<8	4
% people dying in their place of choosing	-	84.4%

Further details of the number and type of incidents reported can be found in our Quality Account. We place great focus on reporting of and learning from incidents. Trends are reviewed and all incidents highlighted in the table above are comprehensively investigated. Very encouragingly we are performing well in respect of our safer staffing fill rates.

Improve the use of resources		
KPI	**Target**	**Year-End Performance**
CQUIN achievement	£4.2m	£4.0m
Trust Surplus	£1.0m	£1.1m
Agency spend	£5.6m	£5.8m
Cost Improvement Projects (CIP) delivery	£8.3m	£7.5m
Sickness absence	4.5%	5.2%
Mental Health Act Training	80%	84.7%
Mental Capacity Act Training	80%	90.7%

Whilst we did not achieve all of our CQUIN indicators we worked very hard to deliver many of the quality indicators which resulted in us improving our performance compared to the previous year. As stated elsewhere in this report whilst we did exceed the cap on agency spend we were successful in reducing spend compared to 2016/17 by 41%. Our delivery of cost improvement projects fell below our plan by £0.8m, although it must be emphasised that £7.5m of savings were generated in the year.

Our focus on mandatory training is strong. For the majority of training we are meeting the target established. Following a recommendation from the Care Quality Commissioning (CQC) we agreed to make training of the Mental Capacity Act and Mental Health Act mandatory from 2016/17. Compliance with the target of 80% for both was achieved in the year.

We compare favourably with other trusts of our type when it comes to sickness absence. However we are always striving to improve and we are working closely with our staff and staff-side representatives to improve the health and wellbeing of our staff such that we can improve upon the sickness absence rate of 5.2%.

As previously stated, in order to ensure there is a balanced approach to monitoring organisational performance a range of other metrics are reviewed regularly at both Trust Board and other forums. These include the Executive Management Team meeting on a monthly basis, as well as our Operational Management Group and within each of our Business Delivery Units (BDUs). Examples of these metrics include quality, customer focus and workforce

Strategic goals

In 2017/18, the Trust reviewed our strategic direction and produced and agreed a refreshed organisational strategy. This refresh confirmed our mission to ‘help people reach their potential and live well in their community’. We pride ourselves in being a values driven organisation, something that has been recognised by our regulators. The Trust values which underpin our approach as an organisation are:

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent

- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

Our refreshed strategy contains three strategic objectives which are aligned to the same broad 'triple aim' as our partners in the health and care system, these are to:

- Improve people's health and wellbeing
- Improve the quality and experience of all that we do
- Improve our use of resources

In the strategy we also identified four strategic ambitions:

- Regional centre of excellence for specialist and forensic mental health and learning disability services.
- A strong partner in mental health service provision across West Yorkshire and South Yorkshire.
- A host or partner in four local integrated care partnerships - Barnsley, Calderdale, Kirklees and Wakefield.
- An innovative organisation with coproduction at its heart, building on Creative Minds, Recovery Colleges, Mental Health Museum and Altogether Better.

In 2017/18 we made the following progress against the achievement of our three strategic objectives:

Improving health

Joined up care
During 17/18 we have undertaken a significant amount of work in integrated care partnerships in each of our four local areas.

In Barnsley we have become established as a key partner within the Barnsley Health and Care Together Integrated Care Partnership. This brings partners together from across the system to develop new models of care and integrated clinical pathways e.g. diabetes, respiratory, and intermediate care, CVD, and frailty. We have entered into a provider alliance contract that aligns providers around achievement of improved outcomes for the residents of Barnsley. As part of the Alliance agreement all providers are working jointly on the development and implementation of a new model for respiratory services, diabetes services and Intermediate Care

We have worked with the system leadership **in Calderdale** to develop a single plan for Calderdale that sets out the vision to improve, health, social and economic outcomes for local residents. This work is underpinned by a memorandum of understanding and collaborative work on a shared outcomes framework building on the approach developed through the successful local vanguard.

In Kirklees a major focus of our partnership working has been around the provision of integrated children's health services where we play a significant part through the delivery of CAMHs services.

The **Wakefield** Accountable Care Partnership has continued to progress the integration agenda through the New Models of Care Board, underpinned by an alliance arrangement. The Trust is a key partner within this partnership and in particular we are leading the Mental Health work stream to develop an alliance of mental health providers across the system. Work has commenced on developing new models of care that will improve experience,

outcomes and the use of resources starting with the Personality disorder care pathway. As part of the Wakefield Care Home Vanguard the Trust has provided Portrait of a Life training and support session on life story work and person centred care interventions provided to 13 care facilities.

Improving people's experience
The experience of people who use our services is extremely important to us. Although our results from measures such as the friends and family test are good we constantly strive to make this even better. During 2017 /18 we have relaunched our experience focus and commitment across the organisation with new branding and core principles using the campaign #allofusimprove which aligns all the different pieces of improvement work. We have focused on making sure that the feedback we receive is acted upon and that people are aware.

Recovery based approaches
In the Trust we are proud of the work that we do, in line with our mission to help people live well in their community. In 2017/18, we have progressed work to align the work of Altogether Better, Creative Minds, the Mental Health Museum, Recovery Colleges and Spirit in Mind which are all innovative examples of this work. We have developed a Recovery College within our forensic services and this has received excellent feedback from the learners who have attended. Our drive to evaluate these different approaches continues with measures that consider the impact for the individual, the organisation and the community.

Improving care

Patient safety
The Trust has in place a comprehensive patient safety strategy which includes key actions to ensure and enable the highest possible patient safety in our services. Key actions have been undertaken, in line with this strategy, these include:

- Development of safety huddles
- Establishment of mortality review systems
- Continued development of learning from incident systems

West Yorkshire work
The Trust is a member of the West Yorkshire & Harrogate Health and Care Partnership. Over 2017/18, this partnership has matured and we have increased the amount of work that is undertaken within this framework to improve care and services across this whole area. This includes:

- Partnership in a successful bid for capital funding to build an inpatient CAMHS service
- Leading work to develop and deliver a plan to reduce suicides drawing together partners across STP areas and in each locality.
- Leading the provision of a community forensic CAMHS services across Yorkshire and Humberside in partnership with: Sheffield Children's Hospital; Tees, Esk and Wear Valleys FT and; Humber FT.
- Supporting the Leeds and York Partnership NHS Foundation Trust as lead provider in the provision of a West Yorkshire wide new model for community treatment services for adults with eating disorders Eating Disorders

Leadership and management development

In 2017/18, the Trust values have been used as a basis to develop behaviours for staff which are in line with the values (see following diagram). These have been incorporated into a revised appraisal process. A comprehensive Learning Needs Analysis has been completed and this is being used to guide training and development resources. In February we launched a new Leadership and management framework which sets out the leadership and management development path for all staff, however experienced or senior they are. Development programmes are in place for key groups such as middle managers and TRIOs.

Values into behaviours

Integrated change and quality improvement

At the end of 2016, we undertook a review of our approach to change management considering both the processes we were using and the impact that we were having. This review informed the development of an Integrated Change Framework which:

- is in line with our values and behaviours;
- includes actions to build capacity and capability so that people are skilled and can easily carry out improvements at all levels;
- encourages innovation and improvement. This includes the use of i-hub (our crowd sourcing platform for good ideas);
- has 3 levels of change. The level chosen is proportionate and depends on the risk/complexity/cost; and
- set out our priorities for focus over the coming year.

The Integrated Change Framework is a cornerstone in the newly approved Trust Quality Strategy which sets out the quality improvement approach and initiatives for the future.

Improving resources

In 2017/18, the Trust has undertaken significant work to improve our use of resources. This includes:

Use of agency staff
During 2017/18, we have made positive progress on agency spend with expenditure reducing by 41% compared to the previous year. This has been achieved by a number of means including recruitment into a number of positions, attaining cost per shift targets more frequently and improved staff rostering. Focus will remain such that this level of reduction can be sustained and improved upon. Reducing the proportion of workforce expenditure on agency staff, as opposed to Trust employees, enables us to increase our input into direct clinical care. Full year expenditure of £5.8m is 4% higher than the cap set by NHS Improvement.

Use of out of area placements
The use of out of area bed placements is an issue the Trust and its partners are striving to reduce. Demand for inpatient beds for our adult acute and Psychiatric Intensive Care Unit (PICU) has been inconsistent during the year and has been extremely high during the last two months of the year. Expenditure on out of area bed placements for adult acute and PICU service users totalled £3.7m in the year and amounted to 5,044 days.

Achievement of Financial Control Total
During 2017/18, we over-achieved against our financial control total of £1.0m target set by NHS Improvement, delivering £1.14m before "one-off" costs and income. This achievement was only possible by a range of non-recurrent measures such as the sale of trust property no longer required. The underlying financial position was actually a deficit. This entitled us to access additional funding by means of the Sustainability and Transformation Fund (STF) of £2.9m.

Clinical record system
Following a thorough tender and evaluation process the Trust has agreed to change to a new supplier for the clinical record system for mental health services. A significant amount of engagement and involvement of staff was undertaken in order to make this decision and a plan and team are now in place to safely implement a replacement system which supports high quality care.

Digital health
A pilot project has taken place within our CAMHS team to trial the use of an apps platform to help make people make more informed decisions when it comes to health and wellbeing apps. These apps have been independently evaluated and the platform is provided for service users to access.

Quality and quality governance

Improvement and innovation for quality is about making healthcare safe, effective, service user centred, timely and efficient. Our key driver is to ensure that we should systematically improve quality throughout our services, strive to support our services users to achieve positive outcomes and live life to the full and reduce unnecessary clinical variation.

We believe strong clinical leadership, supported by opportunities for innovation and robust governance arrangements will help us deliver a culture where high quality services will flourish.

Quality improvement is a priority at Board level and throughout the Trust. Quality improvement is routinely reported to our Trust board through the recently revised Integrated Performance Report. The Executive Lead is the Executive Director of Nursing and Quality. The Clinical Governance and Clinical Safety Committee is led by the lead Executive Director and a Non-Executive Director. This Committee reports directly to the Trust Board (see page 49). A number of standing sub-groups which cover quality and safety matters are chaired by the Medical Director, Director of Nursing and Quality or their deputies and report directly to the Clinical Governance and Clinical Safety Committee.

We have aligned our strategic objectives, priorities and programmes and quality initiatives and we will use these as a framework to focus improvement, innovation and monitor assurance. In addition we will ensure all our improvement efforts will make the best use of expertise and resources.

Throughout 2017/18, 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 our Quality Account 2017/18. Below is a summary of our performance against 2017/18 quality priorities:

	No. of priorities	**RAG rated summary of performance**
Safe	8	6 rated green, 2 rated amber, 0 rated red
Effective	7	7 rated green, 0 rated amber, 0 rated red
Caring	10	7 rated green, 2 rated amber, 1 rated red
Responsive	4	2 rated green, 0 rated amber, 2 rated red
Well Led	3	3 rated green, 0 rated amber, 0 rated red
Total	**32**	**25 rated green, 4 rated amber, 3 rated red**

In this context RAG rating are used to identify status of performance with RAG representing Red, Amber and Green

Our financial performance 2017/18

This section and the accounts have been prepared in line with appropriate guidance including the Group Accounting Manual for NHS Foundation Trusts 2017/18 and under direction issued by NHS Improvement 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. The Trust accounts can still be viewed in isolation.

Income

The Trust generated an annual income of £222.9m in 2017/18, which was £7.0m (3.1%) lower than the annual income in 2016/17. £208m (93%) of this income is provided from CCGs, NHS England, Local Authorities and other NHS bodies for the provision of healthcare services. Other income relates to such items as Education and Training, Research and Development, and the Sustainability and Transformation Fund. The majority of contract income is commissioned as a fixed payment; however 2.5% (£4.2 million for 2017/18) is based on the achievement of key quality indicators. The Trust has provisionally achieved 95% of these quality indicators.

	Year Ended 31 March 2018 £000s	Year Ended 31 March 2017 £000s
Income from patient care activities	208,032	213,967
Other operating income	14,848	15,940
Operating Income from continuing operations	**222,880**	**229,907**
Operating Expenses	(215,451)	(227,203)
Operating surplus/(deficit)	**7,429**	**2,704**
Finance income	66	66
PDC Dividends payable	(3,393)	(3,110)
Net Finance costs	**(3,327)**	**(3,044)**
Gains/(losses) on disposals of assets	425	9
Surplus/(Deficit) for the Year	**4,527**	**(331)**
Impairments	(1,719)	(186)
Revaluations	9,841	465
Total Comprehensive Income (Expense) for the year	**12,649**	**(52)**

In total the Trust delivered a surplus of £12.6m in the year. It must be emphasised that £9.9m of this was driven by a revaluation of the properties we own. In addition the Trust received non-recurrent Sustainability and Transformation Funding (STF) from the Department of Health of £2.9m given the fact that we achieved our financial targets for the year. There was also an asset impairment (reduction in value) of £1.8m.

In light of the continued financial pressure in the NHS and wider public sector combined with ongoing increases in demand for our services this is a reasonable financial result in the year and is reflected in the approach taken by all our staff of managing financial resources as effectively as possible.

Operating Expenses

Our operating expenses were £215.5m, which compares to £227.2m in the previous year. £166.6m of this cost is attributable to employee costs, which is £4.6m lower than the value of spend in the previous year following the impact of reductions in income, pay inflation and cost savings. As with any year a number of events and issues materialised which led to variations in financial performance across the year. One such example, as was the case in the previous year, is the usage and associated cost of out of area bed placements. Demand fluctuated during the year, but there was particularly high cost in February and March. The total overspend for out of area beds amounted to £3.7m. This was despite additional capacity being made available during the year as the Unity ward opened in October. We continue to place significant focus on out of area bed pressures and remain committed to tackling the issue. We are working closely with our commissioners and other local NHS providers to make improvements. We will strive to keep people as close to home as possible, which also results in lower costs. We did receive a final insurance settlement in relation to the use of out of area beds following fire on Priory Ward in 2016 totalling close to £0.5m during the year.

Another notable area of spend is that of temporary staffing. The agency ceiling set by NHS Improvement for 2017/18 was £5.6m This meant a significant reduction was needed in order to meet it given the fact our agency costs in 2016/17 were £9.8m. We are pleased to report our spend for this year was £5.8m, which represents a 41% reduction in just one year. This was achieved through adherence to nursing pay rates, improved recruitment and improved rostering.

Cost Savings

In order to achieve our financial targets in-year savings of £8.3m were planned for. Savings of £7.5m were delivered, meaning a shortfall against plan of £0.8m. Of the £7.5m achieved £5.9m (79%) was delivered in line with plan, with a further £1.6m achieved non-recurrently through replacement schemes and specific mitigations such as reducing discretionary spend.

Capital

Our capital budget for the year was £10.8m. Ultimately we incurred expenditure of £10.0m. The focus of the programme included Fieldhead Non Secure re-development (£7.0m), a range of minor capital works across our estate and IT improvement schemes. IT investment focussed on improving and moderninsing our IT infrastructure and implementing a new Clinical Record System. The work on the Fieldhead Non-Secure re-development continues into 2018/19. Following national income being made available we have been able to expand the use of wi-fi for the public across many of our sites.

Cash

The closing cash position was higher than plan at £26.6m. This was largely due to lower than expected capital expenditure, earlier than planned receipts from asset disposals and focus on working capital management Cash is expected to reduce next year as major capital development work concludes.

Outlook

2018/19 will not be any easier in terms of the financial challenge for the Trust and wider NHS. Income growth is minimal, whilst demand and cost inflationary pressures continue. For 2018/19 close to £10m savings need to be delivered in order for the Trust to achieve its financial plan. For the first time the Trust is projecting a small deficit next year, which has been agreed by our regulator. To achieve this we need to focus on how we can continually be more efficient, eliminate waste and work closely with our partners to re-design service models and pathways.

Evidence of good practice in financial management

Treasury Management

As a Foundation Trust we are able to generate income by investing cash. During 2017/18 the Trust has invested with the National Loan Fund (NLF). This is a low risk form of investment when compared with many alternatives, but typically provides a higher rate of return than maintaining all cash balances with the Government Banking Service (GBS). In total £65k interest income was earned during the year compared to £66k in the previous year.

The Trust makes payments in line with the NHS Better Payment Practice Code and in the year 97% of creditor payments were made within 30 days, which compares to 95% in the previous year. The Trust was not required to make any payments to suppliers under the Late Payment of Commercial Debts (interest) Act 1988.

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

International Financial Reporting Standards

As part of its annual work programme the Audit Committee has reviewed the accounting policies applied in 2017/18. These were updated for any changes in national guidance. There were no significant changes which impacted on the Trust's reporting requirements or disclosures in the 2017/18 accounts.

Valuation of assets

In line with the Trust's accounting policies, a periodic review of Trust estate has been conducted in 2017/18. In doing so, the appropriate impairment (re-valuation impact both positive and negative) has been reflected in the Trust's accounts.

Recording of investment property

Estate which the Trust Board has declared surplus to requirements is recorded as investment property under International Financial Reporting Standards (IFRS) and its value is updated annually to the current market value. As at March 2018 this is related to one Trust asset. (Southmoor Land – next to Poplars in Wakefield).

Pension Liabilities

The accounting policy for pensions and other retirement benefits are set out in Note 8 to the accounts. Details of senior employees' remuneration can be found in the Remuneration Report section of the annual report.

Auditor's Remuneration

Audit fees (inclusive of VAT) were £62k. This covers both the annual report and accounts, and Quality Accounts. The fee for the independent examination of the charitable funds was £1k.

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 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 2018, the latest year for which information is available, on the Trust's website. The annual report for 2018/19 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.

Service developments

The Trust has developed services during 2017/18. Some of these changes are small scale and local, others cover more than one service and some span the whole Trust. Our Integrated Change Framework has three levels to recognise the different levels of support and governance that each require.

Do and share
Staff are encouraged to carry out small scale service improvements which are low risk and low cost. Many of these are shared on i-hub, our crowdsourcing platform. There are many of these service developments, some examples of actions during 2017/18 include:

- the development of a colourful getting to know you book on the ward as part of a safewards initiative;
- lots of activities to engage people whilst they are an inpatient e.g. come dine with me, pancakes on pancake day; and
- the establishment of a small choir.

Locally governed change
These are service developments that take place at the level of an individual Business Delivery Unit (BDU) or Directorate. In this case the risks and costs are held within the BDU or directorate. There are many of these happening across the organisations, some examples of actions during 2017/18 include:

- the introduction of safety huddles;
- a checklist to develop autism friendly environments which was subsequently adopted by NIHCE; and
- development of visual care plans for people in our learning disability services who were struggling with their written plan.

Trustwide governed change
The areas of change which involve significant risk, cost or complexity are identified within the Trust priorities as Trustwide governance change. Some examples of these are:

In 2017/18, a significant amount of work has been undertaken to co-design and co-create an innovative model for **older people mental health service** with service users, carers and our partners. A business case has been developed which sets out this information including workforce models, quality impact assessments and equality impact assessments.

This year has seen new developments including the implementation of the Community **Perinatal Mental Health team** launched in December 2017. The team provides specialised treatment to women experiencing significant mental health difficulties during pregnancy or if they have a child below one year of age. A new national standard for Perinatal Mental Health was published by NHS England in 2016 and the Trust made a successful bid to the NHS England perinatal mental health community development fund (Wave 1). The Trust was awarded £1.9m to implement and run the new service for the first two years (April 2017 – March 2019) and a service implementation project ran from January 2017 to the launch of the new service. A targeted awareness training programme for key Trust staff was delivered to over 300 staff in 2017 and joint training has also been delivered with midwives and health visitors to external partners. A multi-agency steering group continues to oversee the project this year.

We were also successful in securing a contract to provide **Forensic Child and Adolescent Mental Health Services (CAMHS) support** across the region.

Successful bids
NHS England approached the Trust to request a business case for a **Forensic Outreach Liaison Service (FOLS)** for the region and we have been advised that this has been successful. Discussions with commissioners are in place to work towards implementation.

We have been successful in our bid to host an **Operational Delivery Network for Learning Disability Services** across the region. This will be fully implemented in 2018/19.

Care Quality Commission (CQC) inspection

During two weeks in March 2018, CQC undertook unannounced visits to six of our core services. All of these services had previously received either ‘must’ and ‘should’ do actions from previous CQC inspection visits. The aim of the visits was to look at whether our teams and services had satisfactorily addressed the outstanding issues. The core services visited were as follows:

- Acute wards and PICU for working age adults
- CAMHS
- Forensics
- Community LD and autism
- Community mental health services
- Inpatient LD service

As an organisation we welcomed the CQC visit as an opportunity to show them the progress we have made in improving the quality and safety of our services. We also acknowledge that in some areas further improvements are needed and therefore welcome the role of CQC as an external body and our regulator to provide feedback on our achievements and about what we can do better.

On 9 April 2018, CQC conducted their announced well-led review of our organisation over a three day period. This included interviews with key individuals, a number of focus groups and looking at information files of live cases in relation to such things as ongoing complaints and serious incidents. We did receive some verbal feedback at the end of the well-led review which provided positive feedback and some identified areas for improvement.

The feedback centred on the well-led review as the core service visit high level feedback has already been received. The head of inspection for the well led review started the feedback by saying that it was a privilege and a pleasure to walk into such a welcoming organisation.

They explained that there are areas where they have requested further information before determining their view. We submitted further information to assist their understanding of our position.

They then reported a number of very positive findings:

- Strong engagement, both internal and external.
- Great culture, open and honest with a clear focus on the individual.
- Excellent Disclosure and Barring Service (DBS) system – the best they have seen with a genuine focus on safety.
- Strong senior management visibility and with an open and approachable style.
- Very strong strategy development that is taken very seriously by executive team.
- Good clinical and internal audit processes.
- Really good serious incident and mortality review process.
- Good leadership and management development and succession planning.

In closing, they said that it was great to see such friendly teams, open to new ideas and challenge, in services where people "had a smile on their faces".

The core service visit reports are being written up and quality assured. These will go into a process with the well led review of "rating assurance meetings" in mid-May 2018. We will then have ten days to do our factual accuracy checks and publication will be within 65 days of the well led review.

At the time of writing this report we have not received our core service reports and are expecting these along with the report from our well-led review around May/June 2018. On receipt of our reports we will be given a ten day period to make comment on any factual inaccuracies before the reports are publicised.

Environmental matters - Working in partnership with our stakeholders

The Trust is an active participant in West Yorkshire and Harrogate Health & Care Partnership and the South Yorkshire and Bassetlaw Integrated Care System. Through these partnerships we work with health and care providers and commissioners to improve outcomes, quality and use of resources across a wider geographical footprint. During 2017/18 these partnerships have strengthened considerably and the work has increased in pace.

In **West Yorkshire and Harrogate Health and Care Partnership** we have:

- Commenced the development of a Memorandum of Understanding.

- Commenced work on harnessing the power of communities.
- Joined with other mental health providers to develop a collaborative to strengthen partnership arrangements and our working together.
- Focused on the following areas of improvements:
    - Out of Area Beds;
    - A successful bid for capital funding to support the development of a CAMHs inpatient unit to address the regional shortages in in-patient care;
    - New models of care for specialist Eating Disorder services;
    - Suicide prevention – a plan to realise our ambition of zero suicides;
    - An integrated provider approach to low and medium secure mental health provision;
    - Mental Health Liaison; and
    - Mental Health rehabilitation and out of area high cost placements.

In **South Yorkshire & Bassetlaw Integrated Health and Care System** we have:

- Engaged in the South Yorkshire Hyper Acute Stroke Service Review.
- Focused on the following areas of improvements:
    - Mental Health Liaison; and
    - Mental Health sharing best practice and learning through management and clinical networks in the development of perinatal services, IAPT and Out of area placements.

The Trust is also a key partner within the Integrated Care Partnerships in each of the four districts where we work. In Barnsley, this is the Barnsley Health and Care Together Integrated Care Partnership. In Calderdale, this is as part of the system to develop a single plan for Calderdale. In Kirklees, our major focus of our partnership working is around the provision of integrated children's health services, and in Wakefield, we are members of the New Models of Care Board and the strategic lead for strengthening partnership working in Mental Health across the system and developing new models of care the ensure we deliver integrated joined up care pathways that meet the needs of local residents.

Social, community, anti-bribery and human rights issues

We aim to ensure that everyone who needs to, can access Trust services and that we have a workforce which represents the communities we serve, that is free from discrimination and harassment in line with our values.

Delivery against this agenda is regularly monitored by the Trust's Equality and Inclusion Forum. The Forum was established to support a values based approach to equality and inclusion, rather than a traditional compliance based approach. It is chaired by Angela Monaghan, Trust Chair. The Forum receives regular updates and reports on our progress around the Equality Delivery System 2 (EDS2) and the Workforce Race Equality Scheme (WRES), together with feedback from other sources such as staff surveys to allow the Trust to build on its strengths and to put in place action plans to address any weaknesses.

Our Annual 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 (EIAs) to ensure our services take account of need, especially where services are developing and changing. We launched our new *Equality Strategy* in July 2017. This strategy supports us in living our values and maintaining positive practices. It will also help us deliver against our statutory duties set out in the Equality Act 2010, including the Public Sector Equality Duty. 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 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. The Trust has human resources policies in place, which can be found on the Trust's website, which promote equality of opportunity in employment. We continue to work with our commissioners, service users and carers to evaluate our progress in each of these areas.

The Trust has recently revised and approved its Human Rights Statement and Guidance. Public authorities in the UK have obligations to promote and protect human rights, and all public authorities must act in a way that is compatible with the European Convention on Human Rights. This means treating individuals fairly, with dignity and respect, whilst also safeguarding the rights of the wider community. South West Yorkshire Partnership NHS Foundation Trust is committed to ensuring all its services respect human rights, treat people fairly and equitably, recognise the needs of the diverse communities we serve and meet local needs. Although the Trust is not classed as a "commercial organisation" for the purpose of the Modern Slavery Act 2015, we have taken a number of steps to ensure that slavery and human trafficking is not taking place in any of our supply chains or in any part of our business to the best of our knowledge, through recruitment and payroll processes and the inclusion of statement in contracts we enter into with providers that states that the supplier agrees that it is responsible for controlling its own supply chain and that it shall encourage compliance with ethical standards, human rights, health and safety and environmental standards by any subsequent supplier of goods and services that are used by the supplier when performing its obligations under this Agreement. Further information in relation to compliance with the Supplier Code of Conduct can be found under the Modern Slavery Act section (see page 77).

The Trust has a Sustainability Strategy which runs to 2020. The strategy provides a framework covering national goals as well as energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment and adaptation, organisational and workforce development and partnerships and networks. The work to integrate sustainability into Trust operations, as defined in the strategy is reported to the Trust Board annually in October.

Looking ahead – our strategy objectives

Our strategic objectives in 2018/19 will focus on three aims: improving people's health and wellbeing; improve the quality and experience of all we do; and improve our use of resources. We have identified a number of priority programmes that will enable the Trust to continue to drive improvements and deliver the Trust strategy.

	Improving health	Improving care	Improving resources
Strategic priorities	**Joined-up care** 1. Integrated Care Partnerships in our local areas: • Barnsley • Calderdale • Kirklees • Wakefield	**Safety first, quality counts** 2. Patient safety 3. Quality improvement 4. South Yorkshire projects 5. West Yorkshire projects, including leading on: • Forensic mental health • Suicide prevention • Autism and ADHD • Learning disabilities	**Operational excellence** 6. Flow and out of area beds 7. Workforce productivity 8. Financial sustainability: • Cost improvement programmes • New business
	People at the centre 9. Experience and involvement		
	Compassionate leadership 10. Leadership and management development		
	Digitally enabled 11. Digital infrastructure 12. Clinical record system		

The Trust's plan for 2018/19 sets out an in-year planned deficit (pre Provider Sustainability Funding) of £2.6m which has been agreed by NHS Improvement. Our approach to this financial control total remains consistent in that we will endeavour to work towards it subject to our Board being satisfied it can be delivered without compromising patient safety.

Achievement of our planned deficits of £2.6m means that we will need to deliver a challenging cost improvement in 2018/19. Our financial plan assumes cost savings of £9.7m. All are subject to a quality impact assessment and significant programmes will be established with robust project management arrangements.

For 2018/19, there are a number of key areas of focus which will help drive financial improvement:

- **Out of area beds:** We have experienced an increased demand for bed usage to varying degrees since September 2016, leading to a number of people unfortunately being placed out of area. We'll take the learning from measures we have put in place as well as that from other trusts that have been successful in the respect to reduce to reliance on out of area bed placements and deliver a financial saving. We will also work with partners to ensure we make the best use of the bed base across West Yorkshire.
- **Agency spend:** A number of actions are in place to continue to reduce our agency spend, including recruitment and retention, effective rostering and a focus on reducing sickness absence. This is a key part of our cost saving plans.
- **Workforce:** There continues to be firm focus on workforce, particularly staff in non-clinical roles. Additional savings are possible and are being factored into our savings plans. Wherever possible we will utilise vacancies to reduce staffing, to minimise disruption and redundancy costs.
- **Estates:** By delivering our estates strategy, approved in 2012, we have much improved and reduced estate with staff working agilely. We will now maximise use of our estate and continue to reduce the number of buildings we use. We'll make sure we're using our estate as efficiently as possible.

- **Non-pay and contracts:** We will place further emphasis on achieving non-pay efficiencies. We have also negotiated with our commissioners to increase funding for a number of services that were not fully funded.
- **Service transformation:** This is a key part of our plans. We know that substituting services through alternative provision – such as Recovery Colleges' role in CMHTs – can provide good outcomes at lower cost.

Details of any overseas operations

The Trust does not have any overseas operations.

Rob Webster
Chief Executive Date: 25 May 2018

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 NHS Improvement 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. 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 in the table on pages 35-42.

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.

Declaration of interests

The Trust's Constitution requires Board members to declare any personal or business interests which may influence or be perceived to influence their judgement and in accordance with the Standing Orders those interests that are declarable are any which are relevant and material. The Board receives assurance that there is no conflict of interest in the administration of its business through an annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, the Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. Information on Directors' interests as at 31 March 2018 can be found on the Trust's website.

Non-Executive Director declaration of independence

Monitor's (now NHS Improvement) Code of Governance requires the Trust to determine whether it considers all Non-Executive Directors to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed an annual declaration to this effect.

Fit and proper person requirement

There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements.

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 and other directors at 31 March 2018 is as follows.

	Total	**Male**	**Female**
Non-Executive Directors	6	2 (25%)	4 (75%)
Executive Directors	5	5 (100%)	0
Other Directors (non-voting)	5	1 (20%)	4 (80%)

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

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

- The Deputy Chair/Senior Independent Director, with support from the Board and the Members' Council, has a process in place to appraise the Chair annually. The outcome of this appraisal is reported to the Members' Council. The outcome of the Chair's appraisal for 2016/17 was reported to the Members' Council at its meeting in November 2017.
- The Chair of the Trust undertakes annual reviews with Non-Executive Directors.
- The Chair of the Trust undertakes annual reviews with the Chief Executive.
- The Chief Executive undertakes annual reviews of performance against objectives with Executive Directors and his Executive Management Team.

Trust Board 2017/18

Role/name/appointment	Experience	Public Board attendance 2017/18
Chair **Angela Monaghan**  Appointed Non-Executive Director 1 August 2017 to 31 July 2020 Appointed Chair 1 December 2017 to 30 November 2020	• Over 20 years' experience of leading charities and social enterprises at both regional and national level (14 of those as a Chief Executive) and NHS bodies. • Former Chief Executive of a children's hospice. • Former Non Executive Director and Chair of an NHS Primary Care Trust. • Significant experience of non executive roles in a wide range of voluntary and community sector organisations.	5/5
Deputy Chair / Senior Independent Director **Charlotte Dyson**  Appointed 1 May 2015 to 30 April 2018 Deputy Chair / Senior Independent Director from 1 August 2017	• 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.	8/9
Non-Executive Director **Laurence Campbell**  Appointed 1 June 2014 Re-appointed 28 April 2017 to 31 May 2020	• 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.	8/9

Role/name/appointment	Experience	Public Board attendance 2017/18
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, Chair – Leek United Building Society, including Chairing Nominations Committee and being a member of Remuneration Committee, Chair – Invesco Perpetual Pensions Ltd, including being a member of Risk and Audit Committee, NED – Invesco UK Ltd, Governor – Calderdale College. • Magistrate in Calderdale. • Chair – PRISM – a Charity providing alternative education to children excluded from mainstream schooling.	7/9
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.	8/9
Non-Executive Director **Kate Quail**  Appointed 1 August 2017 to 31 July 2020	• Experienced, qualified Public Health professional with deep understanding of social determinants of health & wellbeing & the range of challenges many people face. Developed prevention & early intervention initiatives, using strength based approaches to create strong resilient connected communities & support people to build fulfilling lives. • Member of Advisory Group of self-advocates & family carers which informs & influences the work of Improving Health and Lives Learning Disability Observatory (part of Public Health England). • Was on national Transforming Care steering group, which wrote 'Winterbourne View - Time for Change, which became the Transforming Care Programme to support people in their communities & prevent admission to hospital. • FT Governor for 5 years, including Lead Governor.	5/5

Role/name/appointment	Experience	Public Board attendance 2017/18
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.	7/9
Medical Director **Adrian Berry**  Appointed Director of Forensic Services 1 November 2010 Medical Director 1 October 2014 to 31 March 2018 Deputy Chief Executive from 1 October 2016 to 30 June 2017	• 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.	6/9

Role/name/appointment	Experience	Public Board attendance 2017/18
Director of Nursing and Quality **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.	9/9
Director of Finance and Resources **Mark Brooks**  Appointed 1 June 2016	• 8 years' experience in the NHS. • Chartered management accountant and a fellow of the Chartered Institute of Management Accountants. • Experience working in community and mental health organisations. • Experience in corporate governance, procurement, estates and IT. • Experience in UK and international senior finance roles and chief financial officer.	8/9
Director of Human Resources, Organisational Development and Estates **Alan Davis**  Appointed 1 April 2002 Interim Deputy Chief Executive 1 April to 31 August	• 34 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.	9/9

Role/name/appointment	Experience	Public Board attendance 2017/18
2016 Interim Deputy Chief Executive 1 July 2017	• Investor in People. • Member of the Director team leading FT application for SWYPFT and major acquisition. • 2009 runner up in NHS HR Director of the Year: nominated by Chief Executive and Staff Side Organisations.	

Other Directors*

Role/name/appointment	Experience	Public Board attendance 2017/18
District Director – Forensic and Specialist Services (and Calderdale and Kirklees from 1 October 2016) (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, extended to 30 June 2018	• Successful track record in health care communications, PR and marketing. • 14 years' NHS experience working in both local and national NHS organisations. • 9 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 *

Role/name/appointment	Experience	Public Board attendance 2017/18
District Director – Barnsley and Wakefield (non-voting) **Sean Rayner**  Transitional post as District Director, Barnsley from 22 February 2011 Substantive from 1 April 2012	• Over 25 years' experience in the NHS, with 13 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 *
Director of Delivery (from 1 October 2017) (non-voting) **Karen Taylor**  Interim appointment 9 January 2012 Substantive appointment 1 April 2012	• Over 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 *
Director of Strategy (non-voting) **Salma Yasmeen**  Appointed 12 January 2017	• Former director of nursing services and transformation in Saudi Arabia Former deputy director at a NHS Foundation Trust with responsibility for the mental and physical health care of older people. • Former chief executive of Bradford-based third sector organisation. • Mental health nurse. • Experience in transformation and innovation.	N/A *

* Only voting Directors are required to attend all Trust Board meetings.

The following members left office during 2017/18:

Role/name/appointment	Experience	Public Board attendance 2017/18
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 (left 30 November 2017)	• 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).	6/6
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.	3/4

Role/name/appointment	Experience	Public Board attendance 2017/18
Director of Corporate Development (Company Secretary) (non-voting) **Dawn Stephenson**  Secondment 8 February 2010 Substantive appointment from 1 April 2011 to 31 July 2017	• 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.	N/A*

* Only voting Directors are required to attend all Trust Board meetings.

NHS Improvement's well-led framework

In 2014, Monitor (now NHS Improvement) 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, guidance was issued 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 (CQC) 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.

Following a decision by Trust Board to undertake an independent review of the Trust's governance arrangements in line with Monitor's (now NHS Improvement) well-led framework for governance reviews (which replaced Monitor's quality governance framework and the board governance assurance framework), Deloitte undertook the review in April 2015. 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 with presentation of the key findings to Trust Board and a workshop with the Members' Council. There were no 'material governance concerns' arising from the review. There were a number of developmental areas where Deloitte recommended further work which formed the basis of an action plan with timescales. An update on the progress against the action plan was presented to Trust Board in 2016 and internal audit undertook a review of implementation as part of its audit work for corporate governance arrangements in 2016. This audit received significant assurance.

In March 2018, the CQC carried out both a re-inspection of the Trust and a well-led review. At the time of writing this report the results of this are not known, but we look forward to receiving any insights the CQC can offer us to help us to continue to improve.

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 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 2018. The Audit 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. The Committee met four times in 2017/18 and its membership was as follows:

Name/role	**Attendance 2017/18**
Laurence Campbell, Non-Executive Director - Committee Chair	4/4
Chris Jones, Non-Executive Director	4/4
Julie Fox, Deputy Chair of the Trust (to 31 July 2017) *Committee member to 31 July 2017	2/2*
Ian Black, Chair of the Trust (to 30 November 2017) *Time limited committee member from 1 August 2017 to 30 November 2017	0/1*
Rachel Court, Non-Executive Director *Committee member from 1 December 2017	0/1*

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation.

The Audit Committee has a number of responsibilities in relation to financial reporting. These are set out on the following table with information on how these have been addressed during 2017/18. There were no significant issues in relation to the financial statements during the year.

Financial reporting	**Progress**
The Committee has responsibility for approving accounting policies.	The Committee considered and approved minor wording changes to accounting policies at its meeting in January 2018. 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	The Committee recommended to the Trust Board for approval the annual report, accounts and Quality Accounts at its meeting in May 2017 prior

Financial reporting	Progress
charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	to submission to NHS Improvement (Monitor). This included the Trust's charitable funds. The Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in July 2017. As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2016/17. The Committee also reviewed the external audit report on the production of Quality Accounts for 2016/17. *(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 reviewed its Treasury Management Strategy and Policy in January 2018. 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. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. The Committee received and reviewed the Use of Resources Assessment for 2016/17.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation; - examines circumstances associated with each occasion Standing Orders are waived; - reviews the schedules of losses and compensations on behalf of Trust Board.	Changes to the Trust's Standing Financial Instructions were approved by the Audit Committee and Trust Board in October 2016. Changes to the Trust's Constitution (including the Standing Orders) and Scheme of Delegation were considered by the Committee in January 2017 and approved by the Trust Board in January 2017 and Members' Council in February 2017. There were no occasions when Standing Orders were waived in 2017/18. The losses and special payments report is received by the Committee at each meeting.

As part of its external audit plan, Deloitte tested risks relating to CQUIN income recognition, Barnsley income recognition (specifically relating to Intermediate Care), management override of controls, property valuations and provisions as part of its review of the 2017/18

financial statements. All controls around these risks were found to be appropriate and in line with Deloitte's expectations. No specific recommendations have been made.

The Audit Committee has a number of responsibilities in relation to the Trust's external auditor. These are set out in the following table with information on how these have been addressed during 2017/18.

External audit	**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 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 in October 2017. 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 for Deloitte was approved as part of the re-appointment process in 2015. A formal audit plan was presented to and approved by the Committee in October 2017. This included an evaluation of risk, which is summarised under section 3.1 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 2016/17 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.	The Trust Board have agreed to a change in the terms of reference of the Audit Committee with respect to the provision of non-audit services to be formally approved.

The Audit Committee has a number of responsibilities in relation to the Trust's internal audit and counter fraud functions. These are set out in the following table with information on how these have been addressed during 2017/18.

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 contract for KPMG as the Trust's local counter fraud specialist ended on 30 June 2017. Through a procurement framework and tender process, Audit Yorkshire was appointed as the Trust's Local Counter Fraud Specialist from 1 July 2017.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	Audit Yorkshire presented a programme of work to the Committee in May 2017, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received an annual report for 2016/17 in May 2017.
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.

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 contract for KPMG as the Trust's internal auditors ended on 30 June 2017. Through a procurement framework and tender process, 360 Assurance was appointed as the Trust's internal auditor from 1 July 2017. 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 360Assurance's own Internal Audit Manual.
Review and approval of the Internal Audit strategy and 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 2017/18 was presented to and approved by the Committee in May 2017. 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. In 2017/18, 8 internal audit reports were presented to the Committee. Of these, there were: - 6 'significant assurance reports; - 2 'limited assurance reports (Preparedness for Implementation of GDPR, Additional Pay Spend (Agency / Bank / Overtime)) Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360Assurance. In the main, there are no significant outstanding actions. The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2016/17. 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.
An annual review of the effectiveness of internal audit.	Performance is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report.

Internal Audit	Progress
	The Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit in 2016/17. This will be repeated in 2018/19.

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

- The Annual Governance Statement is 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

Fees and charges (income generation)

There is no income and full cost to report associated with fees and charges levied by the trust where the full cost exceeds £1 million or the service is otherwise material to the accounts.

Income disclosures required by Section 43(2A) of the NHS Act 2006

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 than 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.

Statement as to disclosure to auditors (s418)

For each individual who was a director at the time that the report is approved:

- so far as the director was aware, there was no relevant audit information of which the NHS foundation trust's auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

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. The Committee met five times in 2017/18 and its membership was as follows:

Name/role	Attendance 2017/18
Julie Fox, Deputy Chair of the Trust (to 31 July 2017) *Chair of the Committee to 31 July 2017	2 / 2*
Charlotte Dyson, Non-Executive Director (to 31 July 2017), Deputy Chair of the Trust (from 1 August 2017) *Committee member to 31 July 2017, Committee Chair from 1 August 2017	5 / 5
Rachel Court, Non-Executive Director *Committee member 1 August 2017 to 30 November 2017	0 / 2*
Ian Black, Chair of the Trust (to 30 November 2017) *Committee member to 30 November 2017	3 / 3*
Angela Monaghan, Chair of the Trust (from 1 December 2017) *Committee member from 1 December 2017	1 / 1*
Kate Quail, Non-Executive Director (from 1 August 2017) *Committee member from 1 December 2017	1 / 1*
Dr Adrian Berry, Medical Director	2 / 5
Tim Breedon, Director of Nursing and Quality - Lead Director	5 / 5
Alan Davis, Director of Human Resources, Organisational Development and Estates	3 / 5
Dawn Stephenson, Director of Corporate Development and Company Secretary *Committee member to 31 July 2017	2 / 2*

District Directors and the Deputy Director of Nursing and Quality are in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Clinical Governance and Clinical Safety Committee by invitation.

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. The Committee met five times in 2017/18 and its membership was as follows:

Name/role	Attendance 2017/18
Chris Jones, Non-Executive Director - Committee Chair	5 / 5
Ian Black, Chair of the Trust (to 30 November 2017) *Committee member to 30 November 2017	2 / 3*
Kate Quail, Non-Executive Director *Committee member from 1 December 2017	2 / 2*
Julie Fox, Deputy Chair of the Trust (to 31 July 2017) *Committee member to 31 July 2017	1 / 1*
Laurence Campbell, Non-Executive Director *Committee member from 31 July 2017	2 / 3*
Dr Adrian Berry, Medical Director / Deputy Chief Executive - Lead Director	4 / 5
Tim Breedon, Director of Nursing and Quality	4 / 5
Dawn Stephenson, Director of Corporate Development and Company Secretary (to 31 July 2017) *Committee member to 31 July 2017	1 / 1*
Salma Yasmeen, Director of Strategy *Committee member from 1 August 2017	3 / 3*

Representatives of the four local authorities, a representative of the three acute trusts covering the Trust's geography, a representative from the District Directors, and one Associate Hospital Manager (as nominated by the Hospital Managers' Forum) are invited to attend meetings. The Assistant Director, Legal Services, is in attendance at meetings. The Chief Executive, other Directors, and relevant officers attend the Mental Health Act Committee by invitation.

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 as a time limited forum by Trust Board in May 2011 to provide assurance to Trust Board on the development and implementation of the Trust's Estates Strategy. The Forum was chaired by a Non-Executive Director and had Non-Executive and Executive Director membership. Invited attendees included the Strategic Planning lead, Capital Projects and Estate Planning and the Head of Estates and Facilities. The Forum did not need to meet in 2017/18 and Trust Board agreed to formally abolish the Forum in January 2018.

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. Invited attendees include a Governor, Human Resources lead, Equality and Engagement lead, and a Staff Side Equality lead.

Members' Council

For the Members' Council role in governance arrangements, refer to section NHS Foundation Trust Code of Governance (see page 68).

Enhanced 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. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance. Trust Board and the Executive Management Team receive monthly Integrated Performance Reports which include 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 2017/18.

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 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 and reports arising from the Care Quality Commission.

Patient care

One of the quality priorities in 2017//18 was 'Caring'. By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect. 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. 'Caring' quality initiatives in 2017/18 were:

- Friends and Family Test.
- Accessible service user experience information for people with dementia.
- Develop volunteering strategy to support service user experience.
- Quality of care plans.

Further information is within the Quality Accounts for 2017/18.

Stakeholder relations

The Trust continues to work in partnership with its staff, stakeholders and partners. Key activity during 2017/18 has focussed on implementing our communications, engagement and involvement strategy, as well as national initiatives and the continued development of sustainability and transformation partnerships, integrated care systems and place-based plans.

Further information can be found under the working in partnership with our stakeholders in the performance analysis section (see page 29).

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.

The Trust operates a local Clinical Excellence Award Scheme based for consultant medical staff based on the previous national employer-based awards scheme. This scheme has been held in abeyance in 2017/18 pending the outcome of national negotiations. 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 2017/18, there was a decision to cease the Directors' Performance Related Pay Scheme, but no other major decisions on senior managers' remuneration were taken and there were 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 external benchmarking. The Remuneration and Terms of Service Committee determined the remuneration policy for directors with specialist external advice. Any significant changes in directors remuneration is undertaken with the use of external benchmarking data and/or external specialist support. The Trust did not consult the employees on the formulation of the policy.

The terms and conditions for Executive and other Directors are in line with national arrangements under Agenda for Change with the exception of on call payments which are excluded and they are not awarded automatic incremental progression on their salary scale.

The package for senior managers is made up of salary and the NHS pension. The information contained on pages 58-59 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 2017/18.

The Chief Executive and the Medical Director are the only senior managers paid over £150k. 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.

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 2017	31 March 2018
Band of highest paid Director's total remuneration (£000's)	170 - 175	170 - 175
Median total remuneration* £'s	28,374	28,335
Remuneration ratio	6.1	6.2

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

Non-Executive Directors received a 1% uplift in line with the national award during 2017/18. Basic remuneration for a Non-Executive Director is £13,383 per annum against an expected time commitment is at least 2.5 to 3 days per month. This was approved by the Members Council in 2017.

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 £42,925 / £45,450 / £47,975 / £50,500 / £53,555 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. The new Trust Chair was appointed on the minimum of the scale.

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 Committee reviewed the PRP scheme in consultation with directors and agreed that whilst salary benchmarking data showed the scheme was justifiable it was not believed to be appropriate given the current financial climate. The decision of the Committee was to cease the directors' PRP scheme with immediate effect and no awards were made in 2017/18.

Annual report on remuneration

Remuneration and Terms of Service Committee

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; and
- 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. The Committee met six times in 2017/18 and its membership was as follows:

Name/role	**Attendance 2017/18**
Ian Black, Chair of the Trust (to 30 November 2017) *Committee member to 30 November 2017)	4/4*
Angela Monaghan, Chair of the Trust (to 30 November 2017) *Committee member from 1 December 2017)	2/2*
Rachel Court, Non-Executive Director - Chair of the Committee	6/6
Charlotte Dyson, Non-Executive Director	6/6
Rob Webster, Chief Executive (non-voting Committee member)	6/6

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, Organisational Development and Estates, provides advice and guidance to the Committee, and the Committee is provided with administrative support by the Personal Assistant to the Director of Human Resources, Organisational Development and Estates. 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 Company Secretary attends. 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 / 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 six times in 2017/18 and its membership was as follows:

Name/role	Attendance 2017/18
Marios Adamou, Governor – staff elected	3/6
Ian Black, Chair of the Trust (to 30 November 2017) *Committee Chair to 30 November 2017	4/5*
Charlotte Dyson, Deputy Chair of the Trust *Committee Chair in absence of Ian Black	1/1*
Angela Monaghan, Chair of the Trust (from 1 December 2017) *Committee Chair from 1 December 2017	1/1*
Nasim Hasnie, Governor – publically elected	5/6
Andrew Hill, Lead Governor (to 30 April 2017) - publically elected *Committee member to 30 April 2017	1/1*
Jackie Craven, Lead Governor (from 31 July 2017) – publically elected *Committee member from 1 July 2017	3/3*
Ruth Mason, Governor – appointed	4/6
Rob Webster, Chief Executive	5/6

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; and
- 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.

In 2017/18, Chris Jones has stated his intention to not seek re-election as a Non-Executive Director and Rachel Court has agreed to remain on the Board for up to one year. Recruitment for two new Non-Executive Directors will therefore take place during the first quarter of 2018.

Payments for loss of office

In 2017/18, a redundancy payment was made to the Director of Corporate Development in line with the Agenda for Change terms and conditions of service. In accordance with the national terms and conditions this payment was capped at the maximum salary of £80,000pa

and maximum reckonable years of service which is 24. This gave a redundancy compensation payment of £160k.

Payments to past senior managers

In 2017/18, there were no payments of money or other assets to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Rob Webster
Chief Executive

Date: 25 May 2018

Name and Title	31/03/2018						
	Salary	Taxable Benefits	Annual Performance related bonuses	Other Remuneration	Expenses	Pension - Related Benefits	Total
	(bands of £5000) £000	Rounded to 1 decimal place £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to 1 decimal place £000	(bands of £2500) £000	(bands of £5000) £000
Ian Black, Chair (left 30/11/2017)	30 - 35	9.7			0.7		40 - 45
Angela Monaghan, Non-Executive Director (from 01/08/17) Chair (from 01/12/17)	15 - 20						15 - 20
Julie Fox, Non-Executive Director (left 31/07/2017)	5 - 10				0.2		5 - 10
Laurence Campbell, Non-Executive Director	15 - 20				0.3		15 - 20
Charlotte Dyson, Non-Executive Director	15 - 20				0.8		15 - 20
Rachel Court, Non-Executive Director	10 - 15				0.6		10 - 15
Christopher Jones, Non-Executive Director	10 - 15				0.3		10 - 15
Kate Quail, Non-Executive Director (from 01/08/2017)	5 - 10						5 - 10
Rob Webster, Chief Executive	170 - 175	1.6			1.1	27.5 - 30.0	205 - 210
Alan George Davis, Director of Human Resources, Organisational Development and Estates	110 - 115	2.3				17.5 - 20.0	130 - 135
Mark Brooks, Director of Finance and Resources	125 - 130	0.9			0.4	0 - 2.5	130 - 135
Dawn Stephenson, Director of Corporate Development (left 31/07/2017)	25 - 30	3.2		160 - 165	0.1		190 - 195
Timothy Breedon, Director of Nursing, Clinical Governance & Safety	110 - 115	1.2			0.2	20.0 - 22.5	135 - 140
Adrian Berry, Medical Director / Deputy Chief Executive	35 - 40	1.3		115 - 120	0.4	60.0 - 62.5	215 - 220
Sean Rayner, District Director, Barnsley and Wakefield	100 - 105	7.0			0.2	7.5 - 10.0	115 - 120
Karen Taylor, Director of Delivery	100 - 105				0.7	15.0 - 17.5	115 - 120
Carol Harris, District Director, Forensic, Specialist Services, Calderdale and Kirklees	95 - 100				0.6	12.5 - 15.0	110 - 115
Kate Henry, Director of Marketing, Engagement and Commercial Development	95 - 100				0.4	22.5 - 25.0	120 - 125
Salma Yasmeen, Director of Strategy	95 - 100				0.2	25.0 - 27.5	120 - 125

The salary and pension entitlements of senior managers are set by the Remuneration and Terms of Service Committee which is a sub-committee of the Trust Board. The Trust follows national guidance on pay and terms and conditions for senior managers and the contracts are substantive with NHS termination arrangements.

Name and title	Normal retirement age	Real increase/ (decrease) in pension and related lump sum at retirement age	Total accrued pension and related lump sum at retirement age at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase (Decrease) in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		(bands of £2500) £000	(bands of £5000) £000	£000	£000	£000	Rounded to 1 decimal place £000
Adrian Berry, Medical Director / Deputy Chief Executive	55	155.0 - 157.5	305 - 310	1,564	1,393	157	0
Timothy Breedon, Director of Nursing and Quality	65	57.5 - 60.0	90 - 95	654	589	59	0
Mark Brooks, Director of Finance and Resources	65	20.0 - 22.5	15 - 20	235	212	21	0
Alan George Davis, Director of Human Resources, Organisational Development and Estates	60	90.0 - 92.5	210 - 215	1,209	1,107	91	0
Carol Harris, District Director, Forensic, Specialist Services, Calderdale and Kirklees	60	60.0 - 62.5	145 - 150	709	641	62	0
Kate Henry, Director of Marketing, Engagement and Commercial Development	60	17.5 - 20.0	15 - 20	116	95	20	0
Sean Rayner, District Director, Barnsley and Wakefield	60	62.5 - 65.0	155 - 160	809	739	63	0
Dawn Stephenson, Director of Corporate Development (left 31/07/2017)	60	0	0	0	0	0	0
Karen Taylor, Director of Delivery	55	72.5 - 75.0	185 - 190	959	876	74	0
Rob Webster, Chief Executive	60	62.5 - 65.0	205 - 210	926	854	64	0
Salma Yasmeen, Director of Strategy	60	22.5 - 25.0	45 - 50	221	195	24	0

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

A Cash Equivalent Transfer (CETV) is the actuarially assessed capital value of the pension scheme 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 the 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 2005-05 other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increases 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.

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 Workforce Strategy recognises the need to develop and re-design the workforce to ensure it is fit for purpose and sustainable. The strategy has three strategic work streams relating to workforce development and planning, staff engagement and wellbeing, and leadership and management development. The three strategic Human Resources work streams are underpinned by a value based approach to the management and development of the workforce a strong commitment to equality and diversity in the workplace.

The make-up of our Board and staff at 31 March 2018 is outlined below. Information on average staff numbers can be found in the accounts.

	Total	**Male**	**Female**
Non-Executive Directors	6	2 (25%)	4 (75%)
Executive Directors	5	5 (100%)	0
Other Directors (non-voting)	5	1 (20%)	4 (80%)
Staff	**4,273**	**966**	**3,307**

During 2017/18, on average, of 4,122 WTE were engaged 3,672 were on permanent contracts, and 450 on 'other' contracts. This compares to 4,110 WTE in 2016/17 when there were 3,769 staff on permanent contracts and 341 on 'other' contracts.

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 2018 was 12.6%%, which is above the target range of 5 to 10%.

Trust Board set a target sickness absence rate of <=4.5%% for 2017/18; the Trust achieved a rate of 5.2%. 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 2018.

Staff in post by occupation group	**2017/18 FTE**	**2017/18 Heads**
Add professional, scientific and technical	285.3	333
Administration and clerical	755.4	896
Allied health professions	286.3	341
Estates and ancillary	264.2	339

Staff in post by occupation group	2017/18 FTE	2017/18 Heads
Medical and dental	145.5	161
Nursing and midwifery registered	1,168.5	1,304
Students	2.0	2
Total	**3,694**	**4,283**

NB it should be noted that these figures will differ from those reported in the accounts. The above figures are at a point in time (31 March 2018) and those in the accounts represent an average over the financial year.

Equality and diversity			Staff as at 31 March 2018
Age Band	Females	Males	Total
19 and Under	6	3	9
20 – 24	124	21	145
25 - 29	311	52	363
30 - 34	356	97	453
35 - 39	378	113	491
40 - 44	367	124	491
45 - 49	497	161	658
50 - 54	554	190	744
55 - 59	409	125	534
60 - 64	244	64	308
65 - 69	43	17	60
70+	22	5	27
Total:	**3,311**	**972**	**4,283**

Census Group	Grand Total
Asian	4.3%
Black	2.6%
Chinese or Other	1.1%
Mixed	1.0%
White	91.0%
Grand Total	**100.00%**

During 2017/18, 28 redundancies were actioned by the Trust (see below). The exit packages were made in accordance with nationally agreed arrangements. Information for 2016/17 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	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
<£10,000	5	12	5	0	10	12
£10,001 - £25,000	14	18	2	0	16	18
£25,001 - £50,000	5	17	0	0	5	17
£50,001 - £100,000	2	11	0	0	2	11
£100,001 - £150,000	1	1	0	0	1	1
£150,001 - £200,000	1	2	0	0	1	2
Total number of exit packages by type	**28**	**61**	**7**	**0**	**35**	**61**
Total resource cost £'000	**£893**	**£2,265**	**£67**	**0**	**£960**	**£2,265**

In 2017/18 there were 6 'other' departures including contractual payments made to individuals in lieu of notice (0 in 2016/17).

Exit packages non-compulsory departure	Agreements/number		Total value of agreements £000	
	2017/18	2016/17	2017/18	2016/17
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	3	0	£34k	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	0	£5k	0
Exit payments following Employment Tribunals or court orders	3	0	£28k	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**7**	**0**	**£67k**	**0**
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 2017/18 was £160k and the lowest was £5,367. This is against a high of £160k and low of £3,833 in 2016/17.

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 2017/18, the Trust has reported £265k of consultancy expenditure in relation to the provision of advice and guidance outside the normal course of business. This spend is broken down into the following areas:

- advice and guidance to support the Trust's transformation programme;
- project guidance as part of the Trust's Altogether Better programme, a programme designed to create healthier communities and better quality health services; and
- advice and guidance to support the Trust's Estates and Information Management & Technology (IM&T) strategy.

Staff engagement

In 2016/17, the Trust Board approved a Communications, Engagement and Involvement Strategy which includes the active engagement of staff. The Trust's approach to staff engagement includes 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.

The Trust has a Social Partnership Agreement which promotes active engagement and consultation with recognised Staff Side Organisations on employee related policies. Employees related policies are developed and consulted through an Employment Policy Sub Group which consists of Managers, Human Resources representatives and Staff Side Organisations. Policies are consulted with a view to agreement through the sub group and then agreed through the Trust wide Staff Partnership Forum. All employment policies have an Equality Impact Assessment undertaken prior to agreement. This includes the impact on disabled employees.

The Trust has locality Health and Safety groups with an overarching Health and Safety and Emergency Planning Trust Action Group which includes staff side, managers and specialist advisers.

An annual health and wellbeing survey is sent to all staff and results are feedback to all staff and actions plans developed in response by the Wellbeing at Work Partnership Group.

During 2017/18, we focused our staff engagement activities on wellbeing. This was reflected in a new campaign that was launched called #allofus. The campaign covered four key themes:

- Flu vaccinations;
- Stress and anxiety;
- Musculoskeletal; and
- Lived experience.

Staff survey

The annual national NHS staff survey, which aims to improve the working experience of staff in the NHS, was carried out between October-December 2017. The survey was sent to all staff. The response rate was 44%, which is average compared with similar NHS organisations.

2016		2017		
Trust	**National Average**	**Trust**	**National Average**	**Trust position**
44%	44%	44%	45%	Average

The Trust's top 5 ranking results

Top 5 ranking scores	2016		2017		
	Trust	**National average**	**Trust**	**National average**	**Trust Position**
Percentage of staff/colleagues reporting most recent experience of violence	88%	88%	92%	88%	Better than average
Percentage of staff working extra hours	65%	71%	68%	71%	Better than average
Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	59%	58%	62%	57%	Better than average

Top 5 ranking scores	2016		2017		
	Trust	National average	Trust	National average	Trust Position
Percentage of staff satisfied with the opportunities for flexible working	56%	58%	62%	58%	Better than average
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	21%	21%	19%	20%	Better than average

The Trust's lowest 5 ranking results

Bottom 5 ranking scores	2016		2017		
	Trust	National average	Trust	National average	Trust Position
Staff motivation at work	3.85 scale summary score	3.94 scale summary score	3.79 scale summary score	3.93 scale summary score	Worse than average
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	27%	24%	26%	23%	Worse than average
Percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public in last 12 months	29%	28%	30%	26%	Worse than average
Effective team working	3.81 scale summary score	3.87 scale summary score	3.77 scale summary score	3.85 scale summary score	Worse than average
Effective use of patient/service user feedback	3.62 scale summary score	3.68 scale summary score	3.58 scale summary score	3.69 scale summary score	Worse than average

Changes in results since 2016

Where staff experience has improved since 2016:

- Percentage of staff satisfied with the opportunities for flexible working, this has increased from 56% to 62%, the national average is 58%.
- Staff confidence and security in reporting unsafe clinical practice, this has increased from 3.60 to 3.71, the national average is 3.60.

Where staff experience has worsened since 2016:

- Staff satisfaction with the quality of work and care they are able to deliver 3.83 decreased from 3.99.
- Staff satisfaction with level of responsibility and involvement 3.84 decreased from 3.90.
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion 86%, decreased from 90%.

Actions 2017 NHS Staff Survey

The action plan will focus on the following key areas where the results were below average.

Staff motivation and effective team working
'Middle Ground' which is a communication and engagement forum for senior leaders will run in 2018 and will focus on developing healthy and resilient teams. The forum will include ways to increase staff motivation and engagement, promote health at work and encourage positive behaviours. A benchmarking tool for assessing team working will be used and a 'Middle Ground Plus' offer will support improvements in team working and staff experience.

Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
The Trust's Patient Safety Strategy 2015-2018 is supported by a detailed action plan. The Incident Management annual report provides a detailed review of incidents and work being undertaken to improve incident management. Our average reporting rate remains consistent over recent years. In 2017/18 89% of all incidents reported resulted in no or low harm, which is indicative of a positive safety culture. Training is available at dedicated sessions across all localities each month. Staff can book sessions which are then tailored to suit individual needs.

Percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public in last 12 months
A group chaired by the Deputy Director Forensic services is reviewing the support available to staff in dealing with harassment, bullying or abuse from service users, carers etc. 'Safewards' continues to be rolled out across in patient areas. This is a violence reduction programme designed to reduce the use of conflict and containment. During 2018 the Trust will be involved in a research project to enhance de-escalation techniques in adult acute and forensic units and develop and evaluate an evidence-based training intervention.

Effective use of patient/service user feedback
Our new quality improvement campaign, #allofusimprove, covers three key themes:

- Experience of care;
- Patient safety; and
- Operational excellence.

As part of this in April 2018, the Trust is launching the experience of care week. Events and roadshows are being held publicised by the Communications team. The Trust is reviewing the options available for collecting patient/service feedback and will be introducing text message appointment system which will include the family and friends test as a follow up to each appointment. Volunteers are also being recruited to support the collection of data. The Quality improvement team will review the staff survey data to target work as required.

Future priorities and targets

The Trust agreed a Workforce Strategy 2017-2020 and the NHS Staff Survey feedback will be used to review our progress in implementing our strategy.

The Trust continually reviews its approach to gathering and using staff feedback. Annual well-being at work surveys are undertaken as well as listening events led by the Chief Executive.

Review of the NHS Staff Survey action plan

The Trust is developing an action plan in response to the NHS Staff Survey 2017, 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.

High paid 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 2018 and any new arrangements entered into in 2017/18. 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 2018 for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2018	6
Of which: - number that have existed for less than one year at the time of reporting - number that have existed for between one and two years at the time of reporting - number that have existed for between two and three years at the time of reporting - number that have existed for between three and four years at the time of reporting - number that have existed for four or more years at the time of reporting	 5 3 2 1 2
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 2017 and 31 March 2018 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 2017 and 31 March 2018	34
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	34
Number for whom assurance has been requested	34
Of which: - number for whom assurance has been received - number for whom assurance has not been received - number that have been terminated as a result of assurance not being received	 34 N/A N/A

TABLE 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2017 and 31 March 2018	
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	0
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.	0
For the above, details of the exceptional circumstances that led to each of these engagements.	N/A
For the above, details of the length of time each of these exceptional engagements lasted.	N/A

Rob Webster
Chief Executive

Date: 25 May 2018

Section 2.4 NHS 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 Governance, 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.

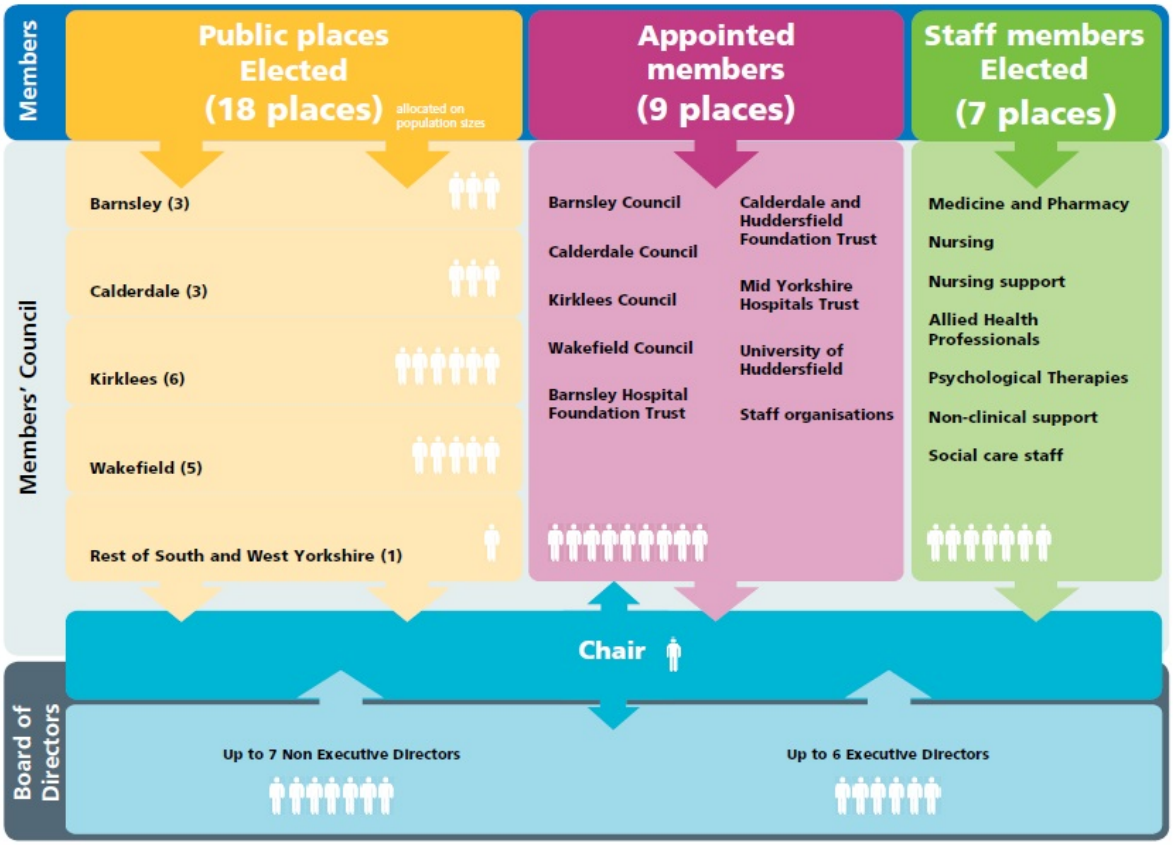
Our Members' Council

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, makes recommendations for the revision of the constitution with the last update occurring in 2016/17. In April 2017, the Members' Council approved a revised Membership Strategy and supporting action plans.

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. Contact can be made with our governors through the membership office, details are available on the Trusts website.

There are 34 places on the Members' Council made up as in the diagram on the following page.



Lead Governor

The role of the Lead Governor is to act as the communication channel for direct contact between NHS Improvement 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.

Andrew Hill was appointed as Lead Governor by the Members' Council in July 2016, following a recommendation from the Nominations Committee, for a period of two years, subject to his re-election as a governor in 2017. Given the outcome of the election in April 2017, a process took place through the Nominations Committee to appoint a new Lead Governor from the publicly elected governors. Jackie Craven was appointed Lead Governor by the Members' Council in July 2017 for a period of two years.

Our governors

The table below sets out the governors in place as at 31 March 2018:

Name/representing	Term of office	Members' Council attendance 2017/18
Lead Governor		
From July 2017 **Jackie Craven** Elected – public Wakefield	1 May 2014 for three years Re-elected 1 May 2017 for three years	4/4

Name/representing	Term of office	Members' Council attendance 2017/18
To April 2017 **Andrew Hill** Elected – public Barnsley	1 August 2011 for 2.5 years Re-elected 1 May 2014 for three years	0/1
Governors		
Shaun Adam Elected – public Barnsley	1 May 2016 for three years	1/4
Marios Adamou Elected – staff medicine and pharmacy	1 May 2012 for three years Re-elected 1 May 2015 for three years	1/4
Neil Alexander Elected – public Calderdale	1 May 2017 for three years	2/3
Bill Barkworth Elected – public Barnsley	1 May 2017 for three years	3/3
Bob Clayden Elected – public Wakefield	1 May 2016 for three years	4/4
Andrew Crossley Elected – public Barnsley	1 May 2014 for three years Re-elected 1 May 2017 for three years	3/4
Adrian Deakin Elected – staff nursing	1 May 2012 for three years Re-elected 1 May 2015 for three years	4/4
Claire Girvan Elected – staff allied health professionals	1 May 2012 for three years Re-elected 1 May 2015 for three years	3/4
Stefanie Hampson Appointed – Staff side organisations	24 February 2016 for three years	2/4
Nasim Hasnie Elected – public Kirklees	1 May 2011 for three years Re-elected 1 May 2014 for three years Re-elected 1 May 2017 for three years	4/4
Lin Harrison Elected – staff Psychological Therapies	1 May 2017 for three years	3/3
Tina Harrison Elected – public Kirklees	1 May 2017 for three years	1/3
John Haworth Elected – staff non-clinical support	1 May 2012 for three years Re-elected 1 May 2015 for three years	3/4
Carol Irving Elected – public Kirklees	1 May 2016 for three years	4/4
David Jones Appointed – Wakefield Council	7 May 2017 for one year	2/3
Ruth Mason Appointed Calderdale and Huddersfield NHS Foundation Trust	8 November 2011 for three years Re-appointed 8 November 2014 for three years Re-appointed 8 November 2017 for three years	3/4
Debika Minocha Elected – public Wakefield	1 May 2017 for three years	1/3
Chris Pillai Appointed – Calderdale Council	8 June 2016 for three years	1/4
Jules Preston Appointed – Mid-Yorkshire Hospitals NHS Trust	13 June 2013 for three years Re-appointed 13 June 2016 for three years	¼

Name/representing	Term of office	Members' Council attendance 2017/18
Caroline Saunders Appointed – Barnsley Council	8 June 2016 for three years	1/4
Phil Shire Elected – public Calderdale	1 May 2016 for three years	4/4
Jeremy Smith Elected – public Kirklees	1 May 2016 for three years	2/4
Richard Smith Appointed – Kirklees Council	2 June 2016 for three years	1/4
Gemma Wilson Elected – staff nursing support	1 May 2016 for three years	0/4
David Woodhead Elected – public Kirklees	1 May 2010 for three years Re-elected 1 May 2013 for three years Re-elected 1 May 2016 for three years	2/4

The following governors left the Members' Council during 2017/18:

Name/representing	Term of office ended/reason
Garry Brownbridge Elected – staff psychological therapies	30 April 2017 Did not stand for re-election
Jessica Carrington Appointed – Wakefield Council	6 May 2017 Was not re-appointed
Andrew Hill Elected – public Barnsley	30 April 2017 Was not re-elected
Chris Hollins Elected – public Wakefield	September 2017 Resigned
Sarah Kendal Appointed – University of Huddersfield	December 2017 Resigned
Daniel Redmond Elected – public Calderdale	30 April 2017 Did not stand for re-election
Ian Turnock Elected – public Calderdale	27 July 2017 Moved out of constituency
Hazel Walker Elected – public Wakefield	30 April 2017 Did not stand for re-election

During 2017/18, the following governors sadly passed away:

Name/representing	Term of office
Michael Fenton, Elected – public Kirklees	1 May 2014 for three years
Bob Mortimer, 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
Peter Walker, Elected – public Wakefield	1 May 2010 for three years Re-elected from 1 May 2013 for three years

Interests declared by governors can be found on the Trust's website.

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 2017/18 was £1,321.60 to 12 governors (against a total in 2016/17 of £1,461.20).

The election process for the Members' Council began in February 2018 for the following seats:

Public
- Calderdale – 1
- Kirklees – 1
- Wakefield – 2
- Rest of South and West Yorkshire – 1

Staff
- Allied Healthcare Professionals – 1
- Social care staff in integrated teams – 1
- Non-clinical support services – 1
- Registered medical practitioners and registered pharmacists – 1
- Registered nurses – 1

The nominations process ended on 2 March 2018 and the following were elected unopposed:

Public
- Wakefield – Kate Amaral and Daz Dooler
- Rest of South and West Yorkshire – Paul Williams

Staff
- Non-clinical support services – Debby Walker

An election was held for the remaining seats, the election process opened on the 26 March 2018 and closed on the 20 April 2018. The following were elected:

Public
- Kirklees – Mike Walker

Staff
- Allied Healthcare Professionals – Lisa Hogarth
- Registered Medical Practitioners and Registered Pharmacists – Marios Adamou
- Registered Nurses – Adrian Deakin

The public seat for Calderdale remains vacant as does the staff seat for social care staff working in integrated teams. There is also an appointed seat vacant for Barnsley Hospital NHS Foundation Trust which is not currently filled.

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 by the Chair to attend Members' Council meetings to ensure they understand the views of our 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. Regularly there are round table discussions on key areas, such as the Trust's plans for transformation and its strategy.

Holding Non-Executive Directors to account for the performance of the Board is a key area for governors, discussion sessions are time tabled to focus on supporting governors to do this. Each Non-Executive Director is 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 has 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 November 2017, governors reviewed the themes emerging from the previous year's strategic meeting and the actions taken by the Trust. They reviewed the planning assumptions and considered a number of key issues and how they could impact on the Trusts' strategic direction. The contribution from governors has informed and contributed to development of the Trust's annual plan for 2018/19.

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.

Strategy and forward plans

- Development of the Trust's Quality Accounts.
- Forward plan for 2017/18-2018/19 (joint meeting with Trust Board) in November 2017.

Statutory duties

- Appointment and re-appointment of Non-Executive Directors.
- Appointment of the Chair.
- Determination of Non-Executive Directors' remuneration.
- Received the annual report and accounts.

Trust activity

- Engagement on Trust plans for transformation
- Attendance at members groups across the Trust.

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 Members' Council Co-ordination Group co-ordinates the work and development of the Members' Council.
- The Members' Council 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 a good 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 *Membership Strategy*, which sets out our ambition over the next three years to effectively communicate, engage and involve our membership, through three high level objectives which are relevant to all stakeholder groups:

1. We will build and maintain membership numbers to meet our annual plan targets, ensuring membership is representative of the population the Trust serves.
2. We will communicate effectively and engage with our public members and our staff members, maintaining a two way dialogue and encouraging more active involvement.
3. We will develop an effective and inclusive approach to give our public members and our staff members a voice and opportunities to contribute to the organisation, our services and plans for the future.

In summary, membership of the Trust means local people and our staff have a greater say in how services are provided in the communities the Trust serves, services take account of local needs and they have a sense of ownership of the Trust. 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 part of our action plan to implement the Membership Strategy we undertook cleansing and strengthening of our membership data base. As at 31 March 2018, we had 9,318 public members (9,654 in 2017/18).

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:

- 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;
- implementation of Membership Strategy action plan;
- on-going development of our governors to reflect governor feedback following development sessions;
- input to transformation work streams to shape future services to ensure they are fit for purpose; and
- supporting staff governors as Freedom to Speak up guardians.

This approach is supported by our vision for volunteering through our members. At 31 March 2018, we have 202 volunteers within the Trust which equates to 773 hours per week, 3,194 hours per month, and 37,808 hours per year. Volunteer roles include health champions, befrienders, co-producers and co-facilitators in recovery colleges, expert patient programme volunteers, meet and greet volunteers, horticulture volunteers, conversation buddies in speech and language service and catering volunteers. The 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. As at 31 March 2018 we had 4,193 staff members (4,643 in 2016/17).

Section 2.5 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters *of 2016/17* relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

NHS Improvement has placed the trust in segment 2 – targeted support. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18				2016/17	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	1	1	1	1	1	1
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	2	2	1	2
Financial controls	Distance from financial plan	1	1	1	1	1	2
	Agency spend	2	1	1	1	4	4
Overall scoring		**1**	**1**	**1**	**1**	**3**	**3**

The overall risk rating for finance and use of resources is 1, which is a positive result for 2017/18. The planned deficit for 2018/19 will result in a deterioration of this particular measure.

Section 2.6 Voluntary disclosures

Equality reporting

Our Annual 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. Further detail can be found in our Annual Equality Report to Trust Board in July 2017 on the Trusts website and under the social, community anti-bribery and human rights issues section of this report (see page 29).

Modern Slavery Act 2015

The Modern Slavery Act 2015 established a duty for commercial organisations to prepare an annual slavery and human trafficking statement. South West Yorkshire NHS Foundation Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

People

- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage
- Our Respect at policies (we would need to name them) additionally give a platform for our employees to raise concerns about poor working practices.
- We have been using training and briefing papers to raise awareness and there has since been investment in training to ensure front line practitioners are aware of and able to respond to incidents of modern slavery within care settings.
- We are committed to partnership working so that professionals can share best practice and work to support the identification of modern slavery in health and social care settings.

Whistleblowing in the NHS

- We have a Whistle Blowing Policy which allows staff to raise concerns about inappropriate activity with us directly.

Procurement and our supply chain

- Our procurement approach follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.
- When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.
- We will deliver training to all Commercial and Procurement staff by quarter 3 2018 on ethical and labour issues in procurement and this will form a key part of our induction for new entrants to the Commercial team.

Review of effectiveness

We intend to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly in our supply chains.

In 2018/19, our anti-slavery programme will also:

- support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working in the NHS can have in keeping present and potential future victims of modern slavery and human trafficking safe.
- ensure that all staff have access to training on how to identify those who are victims of modern slavery and human trafficking. This training will include the latest information and will help staff develop the skills to support individuals who come into contact with health services
- ensure modern slavery and human trafficking are taken seriously and features prominently in safeguarding work plans.

Further information is also provided under the social, community, anti-bribery and human rights issues section (see page 29).

Compliance with the Supplier Code of Conduct

The South West Yorkshire Partnership NHS Foundation Trust reserves the right upon reasonable notice to check compliance with the requirements of the Supplier Code of Conduct. The South West Yorkshire Partnership NHS Foundation Trust encourages its suppliers to implement their own binding guidelines for ethical behaviour. Included in contracts we enter into with providers is the following statement that the supplier agrees that it is responsible for controlling its own supply chain and that it shall encourage compliance with ethical standards, human rights, health and safety and environmental standards by any subsequent supplier of goods and services that are used by the supplier when performing its obligations under this Agreement.

- **Laws and Ethical Standards:** The supplier shall comply with all laws applicable to its business. The supplier should adhere to the principles of the United Nations' Global Compact, UN Declaration of Human Rights as well as the 1998 International Labour Organisation's "Declaration on Fundamental Principles and Rights at Work" in accordance with national law and practice, especially:
- **Child Labour:** The supplier shall not use child labour younger than the age of 15. In no event especially when national law or regulations permit the employment or work of persons 13 to 15 age on light work, the employment shall prevent the minor from complying with compulsory schooling or training requirements and being harmful to their health or development.
- **Forced Labour:** The supplier shall make no use of forced or compulsory labour.
- **Compensation and Working Hours:** The supplier shall comply with national applicable laws and regulations regarding working hours, wages and benefits.
- **Discrimination:** The supplier should promote the diversity and heterogeneity of the individuals in the company with regard to race, religion, disability, sexual orientation or gender among others.
- **Health and Safety:** The supplier shall comply with applicable occupational health and safety laws and regulations and provide a safe and healthy working environment to prevent accidents and injury to health.
- **Business Continuity Planning:** The supplier shall be prepared for any disruptions of its business (e.g. natural disasters, terrorism, software viruses, and medical/infectious diseases).
- **Improper Payments/Bribery:** The supplier shall comply with international anti-bribery standards as stated in the United Nations' Global Compact and local anti-corruption and bribery laws. In particular, the supplier may not offer services, gifts or benefits to South West Yorkshire Partnership NHS Foundation Trust employees in order to

influence the employee's conduct in representing the South West Yorkshire Partnership NHS Foundation Trust.

- **Modern Slavery Act:** The supplier shall fully comply with all aspects of the Modern Slavery Act 2015 which received Royal Assent on 26 March 2015. This Act addresses the issues surrounding slavery, servitude and forced or compulsory labour, human trafficking, exploitation, and includes the provision for the protection of victims.
- **Environment:** The supplier shall comply with all applicable environmental laws, regulations and standards as well as implementing an effective system to identify and eliminate potential hazards to the environment.
- **Business Partner Dialogue:** The supplier shall communicate the above mentioned principles stated in the Code to its subcontractors and other business partners involved in the products and services described in the main contract and motivate them to adhere to the same standards.

Rob Webster
Chief Executive

Date: 25 May 2018

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 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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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* (and the *Department of Health Group Accounting 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 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 the *NHS Foundation Trust Accounting Officer Memorandum*.

Rob Webster
Chief Executive

Date: 25 May 2018

Annual Governance Statement 2017/18

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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*.

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides across a broad geographical area.

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 2018 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 based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Strategy and Risk Appetite Statement.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has matured, in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust and on the Trust's future strategy. Training and development ensures governors have the skills and experience required to fulfil their duties.

The Board includes an Executive team with the day to day responsibility for managing risk. Over the last year, we have had a largely stable Executive Director team. There has been a reduction in the number of Business Delivery Unit (BDU) directors of one, with that individual now fulfilling a Director of Delivery role to focus on operational excellence. The

Director of Corporate Development role ceased during the year with the associated responsibilities transferring to other directors. Executive director portfolios are continually reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

The Members' Council, Board and Executive team are operating in an environment of change and system pressure where risk is constant and at a heightened level.

The Trust operates within a strategic framework that includes a Vision, Mission and Values, supported by three Strategic Objectives and a number of Priority Programmes. This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive objectives and the objectives of the Executive team determined in line with director accountabilities. I review these objectives on an on-going basis with individual directors with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate Scheme of Delegation and Standing Financial Instructions.

The Trust works in partnership with health economies in Calderdale, Kirklees, Wakefield, Barnsley and the Sustainability and Transformation Partnerships of South Yorkshire and West Yorkshire. We identify and manage risk at those levels as well as at Trust level, as reflected in the roles and responsibilities of the Board, of Executives and staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust strengthened its risk management arrangements during 2017/18 by creating a formal Risk Officer role and scheduling regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its sub-committees. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

Risk management training for the Trust Board is undertaken bi-annually. The training needs of staff are assessed through a formal training needs analysis and staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The Risk Management Strategy was updated and approved by Trust Board on 31 January 2017.

Alongside this capacity, the Trust has effective Internal Audit arrangements, with a work plan that helps to manage strategic and business risk within the Trust.

The risk and control framework

The risk and control framework flows from the principles of good governance. It uses effective Board and committee structures, supported by the Trust's Constitution (including Standing Orders) and Scheme of Delegation. The Risk Management Strategy describes in detail how risk is applied within this framework.

The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board on 24 April 2018.

The Audit Committee assessment was supported by an internal audit that was undertaken on Risk Management and the Board Assurance Framework in October 2017 and provided 'significant assurance'. Furthermore, the new Trust internal auditors conducted a survey of Trust Board members in relation to risk management which again supports this assessment.

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 is one monthly 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. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public and the Chair encourages governors to attend each meeting.

The Board has recognised the development of stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and Minutes received by the Board and are reflected in our risks.

The Trust's Risk Management Strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was approved by Trust Board in July 2016 for implementation from September 2016. The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under four categories (strategic, clinical, financial or commercial, and compliance risks), and supports delivery of the Trust's Risk Management Strategy and procedures. Risks that are significant are monitored by the appropriate committee. Over 2017/18, further work has been undertaken to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

During the year, improvements have been agreed with a risk exception report being developed to go to the relevant committee or forum of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work is also taking place to further develop risk tolerance following a discussion at a Board strategic meeting.

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the three strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity and performance management. In 2017/18, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director.

In support of the BAF, the Trust also has a corporate/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 the corporate directorates. These are reviewed regularly at the Operational Management Group. **The Trust's main risks at the end of 2017/18, can be summarised as follows:**

Area of focus	Sample of actions underway
Workforce pressures	Workforce plan being implemented following revised strategy. Focusing on wellbeing and engagement, recruitment and retention (participating in NHS Improvement's support programme).
Acuity and demand pressures	Successfully implemented waiting list initiatives, with more underway. Extra focus on hotspots such as CAMHS and inpatient wards. Continued focus on serious incident reporting, investigations & learning. Greater partnership working with local partners, e.g. Wakefield autism pathway and work across West Yorkshire and Harrogate. Ongoing discussions with commissioners.
Financial sustainability in a changing environment	Enhanced quality impact assessment process introduced. Maintaining focus on quality improvement. Working with NHS Improvement on a financial improvement plan and delivering challenging cost improvement programmes.
Out of area placements	Improved internal controls. Focusing on gatekeeping and flow. Developing a single bed-base across West Yorkshire Mental Health Services Collaborative.
Cyber-crime	Anti-virus software in place, including additional email security and data loss prevention and security patching regime covering all servers, client machines and key network devices. Annual infrastructure, server and client penetration testing. Disaster recovery and business continuity plans which are tested annually. Data retention policy with regular back-ups and off-site storage. NHS Digital Care Cert advisories reviewed on an on-going basis & where applicable applied to Trust infrastructure. Implementation of three year (data centre) infrastructure plan, including security and firewall rules for key network and computer devices, and IT services business continuity and disaster recovery. Increased training for information asset owners and managers.
Tendering activity	Horizon scanning for potential tender activity and work with staff in relevant services. Lessons learned from tenders being systematically actioned. Development of provider alliance in Barnsley. Workforce plan being implemented following revised strategy. Focusing on wellbeing and engagement, recruitment and retention (participating in NHS Improvement's support programme).

Given the strategic context within which we operate, the risks outlined above will continue into 2018/19 with mitigating actions in place. The creation of Sustainability and Transformation Partnerships (STP) across West and South Yorkshire will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the STP in West Yorkshire & Harrogate, I will be able to ensure we are closely engaged in the leadership and delivery of these plans. As an engaged member of the leadership team of the South Yorkshire & Bassetlaw, I will ensure that the risks inherent in the move to an Integrated Care System are understood and mitigated.

Our Licence

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.

The Trust operates under the Single Oversight Framework issues by NHS Improvement which assists the Trust in compliance with the Monitor Licence. Our rating under this framework is 2 – targeted support

The foundation 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 by learning from a regular programme of unannounced visits. Following the CQC visit in March 2016, the Trust developed a new internal visit programme, which initially targeted those services rated as 'requires improvement'. Feedback reports are received and reviewed by BDU management trios, BDU deputy directors and team managers, who develop an action plan to address areas for improvement that are monitored through BDU governance functions. Feedback, lessons learned and good practice from the process are shared with the Clinical Governance and Clinical Safety Committee and used to inform changes to the next planned visit programme.

The Trust is rated GOOD by the CQC. This includes Safety, Caring, Effectiveness and for being Well-Led. We are still rated as 'requiring improvement' for being Responsive and we will continue to address issues in this area.

Our ratings chart shows that 90% of the ratings within our service lines were found to be 'Good' or 'Outstanding'. The CQC found that, without exception, our staff were caring and compassionate as well as respectful and warm towards patients. This reflects a values based culture within the Trust.

The Trust assesses itself annually against the NHS Constitution. A report was presented to Trust Board in December 2017 which set out how the Trust meets the rights and pledges of the NHS Constitution.

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.

Value Based Culture

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 business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture is emphasised in the Values of the Trust and reinforced through values based recruitment, appraisal and induction.

Learning from incidents and the impact on risk management is critical. The Trust uses an e-based reporting system, DATIX, at directorate and service line level to capture incidents and risks, which 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. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced. In 2017/18, 12,303 incidents were reported, of which 89% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based culture.

The Trust works closely with safety teams in NHS Improvement 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 and mitigate future risk.

The provision of mental health, learning disability and community services carries a significant inherent risk. Unfortunately, serious incidents do occur which require robust and well governed organisational controls. During 2017/18, there were 71 serious incidents across the Trust compared to 65 in 2016/17. 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.

Where harm has taken place, the Trust ensures that communication with staff, service users and families is open, honest and occurs as soon as possible following any patient safety event. Our Duty of Candour is taken extremely seriously and staff understand their role in relation to Duty of Candour; they have the support required to comply with the duty and to raise concerns; the Duty of Candour is met through meaningful and sensitive engagement with relevant people; and all staff understand the consequences of non-compliance. This is monitored through the Executive Management Team and reported through the governance structures to Board.

The Clinical Governance and Clinical Safety Committee has a leading role to play. It 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 Trust's action plan in response to the CQC in relation to waiting lists, a review of arrangements for Child and Adolescent Mental Health Services (CAMHS), and a report on improving the quality of the mortality review process. The Committee oversees all work until actions have been completed and closed and it is satisfied that risks have been moderated.

The Clinical Risk Scan, chaired by the Director of Nursing and Quality, 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 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 Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board. The Trust Board approved an updated Quality Strategy on 27 March 2018.
- 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.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. 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 electroconvulsive therapy (ECT), Psychiatric Intensive Care Unit (PICU) and Memory Services, CQC Mental Health Act Visits, national surveys (staff and service user).
- 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.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing approval required before a scheme can proceed.
- 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 annual validation of the Trust's Corporate Governance Statements as required under NHS foundation trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required six areas within the statement.

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 carer feedback, with a consistent approach to action planning and communication of the responses, including assessment against the Department of Health's Friends and Family Test.
- Insight events for members and the public.
- 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.
- The principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.
- Accreditation against the Cabinet Office's Customer Service Excellence award.

This approach 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 continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care in a modern health and care system, developing service change programmes and associated structures to transform the way it delivers services. The priority programmes are focused on ensuring the Trust continues to deliver services that meet local need, offer the best care and better outcomes, and provide value for money whilst ensuring the Trust remains sustainable and viable. The Trust has six priorities with a number of programmes that provide the framework for driving improvements. These include:

- Joined up care - working with our local system partners in each of the places that we provide services including the two integrated systems that we are part of across South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.
- Quality counts, safety first - is a key priority that focuses on programmes to develop and deliver safe, effective and high quality services, including mental health services, learning disability services, general community services and forensic services.
- Operational excellence - focuses on improving productivity, making the best use of all our resources and ensuring that we reduce waste, duplication, unnecessary waste and variation in our care pathways and patient flows.
- Digital by default - ensures we embed the use of technology to improve clinical care and improve our productivity through agile working and the implementation of a new clinical record system.

This is underpinned by our values based culture and our approach to Leadership and a culture of improvement and inclusive change that is co-produced. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the integrated change team.

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 Trust continues its commitment towards carbon reduction. 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 that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and the value of diverse thinking and staffing is secured. This is achieved through Trust policies, training and audit processes. 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 Equality 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 2016/17 suggested that the overall experience of British

Black, Asian, Minority Ethnic (BAME) staff working in the Trust is positive, a number of scores being better than the national average and they were generally more positive than white staff. BAME staff who responded to the survey had a higher overall engagement score, a higher number recommending it as a place to work or receive treatment and a higher number feeling valued by the Trust and senior managers that white staff. Areas where BAME staff were less positive than white staff are harassment and bullying and opportunities for career progression. The Trust has been engaging with staff on developing a new approach to tackling harassment and bullying and a positive action development programme for BAME staff was launched in 2017/18. The BAME staff network was established to empower and support BAME staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives and had a celebration of their first year, which showcased some of their achievements, in October 2017. The Trust has looked to establish a disability staff equality network which is due to start operating in 2018. In 2017/18, the Forum received reports on the following:

- Barnsley pilot for service users into employment.
- initiatives to encourage engagement with young people.
- Dementia awareness.
- Wellbeing survey results.

During 2016/17, we worked with our Members' Council to develop our Membership Strategy which was approved by the Members' Council in April 2017. The key objectives of the strategy, underpinned by a detailed action plan, are:

1. We will build and maintain membership numbers to meet our annual plan targets, ensuring membership is representative of the population the Trust serves.
2. We will communicate effectively and engage with our public members and our staff members, maintaining a two-way dialogue and encouraging more active involvement.
3. We will develop an effective and inclusive approach to give our public members and our staff members a voice and opportunities to contribute to the organisation, our services, and plans for the future.

The Trust has adopted the National Equality Delivery System 2 (EDS2) Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The Trust Board approved a Workforce Strategy in March 2017 which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan which included action on increasing BAME representation in senior roles, including at Board level, career development programmes for BAME staff and a clinical network looking to address harassment and bullying by service users and carers which BAME reporting significantly higher levels than the average.

We ensure Equality Impact Assessments (EIA) are undertaken and published for all new and revised policies and services. This ensures that equality; diversity and human rights issues and service user involvement are systematically considered and delivered, through core Trust business.

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

The governance framework of the Trust is determined by the 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 Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's (now NHS Improvement) 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 Executive Management Team meetings, The Operational Management Group (OMG), BDU management teams and at various operational team meetings. To strengthen financial oversight and challenge Non-Executive Directors are invited to the financial review ate Executive Management 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.

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 local health and wellbeing plans. Increasingly we are ensuring that Sustainability and Transformation Plans (and their successors) inform our work. 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.

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 (QIA) take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The Assessments are led by the Director of Nursing and Quality and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians.

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.

The Trust delivered against its financial control total of £1.0m by achieving £1.1m. This entitled us to receive Sustainability and Transformation Funding (STF) of £2.9m. In total, £7.5m cost savings were delivered against a target of £8.3m (90% delivery). Of the £8.3m, £6.7m was delivered recurrently and a further £1.6m non-recurrently.

Information Governance

Information governance compliance is assured through a number of control measures 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 Senior Information Risk Owner (SIRO). 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 2018.

To strengthen its arrangements, the Trust's approach in 2017/18 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 Executive Management Team, and offering advice and increasing availability of training for staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

In November 2016, the Information Commissioner's Office (ICO) undertook a consensual data protection audit. The final report, which provided reasonable assurance, was issued to the Trust in February 2017 and the executive summary was published on the ICO's webpage and the Trust's website. At each meeting of the Audit Committee an update on the progress made on the actions identified is provided. An update of progress made was provided to the ICO in December 2017. The vast majority of actions have now been completed.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office (ICO). There have been 3 such incidents reported in 2017/18. This is a reduction compared to the nine reported incidents in 2016/17 and they are summarised below together with the actions taken:

- A letter including highly sensitive personal data was sent to a patient's home address despite their request that no correspondence be sent: the letter was opened by relatives who were previously unaware of the patient's diagnoses, causing significant distress to both the patient and their family – actions taken include ensuring outgoing post is checked by a clinician before release and the issue of a briefing paper to the team outlining the principles and practice for patient correspondence.
- A letter pertaining to one patient was left in the home of another by a community nurse after it had been collected from a standalone printer with a leaflet and stapled into the leaflet – actions taken include removing standalone printers from the premises and only using multi-functional devices and briefs at service and team meetings outlining responsibility for checking printed information when collecting from devices and prior to handing over to patients.
- Two highly sensitive reports about children were sent to the other's intended recipients – actions taken include immediately implementing a two-person check of post items before sending and recruiting an additional member of administrative staff to reduce pressure on the team.

Good information governance will continue to be a feature of the Trust in 2018/19. The Information Toolkit was submitted at level 2 – satisfactory.

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. NHS Improvement (in exercise of the powers conferred on 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*. We have fully compiled our Annual Report with the guidance issued, with our Quality Account being published alongside our Financial Accounts to ensure there is a balanced picture of the value delivered by the Trust. Our public and staff members are represented by the Members' Council Quality Group who are fully involved in agreeing the indicators within the Quality Account. Public facing and easy read versions of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Trust Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

Governance and leadership of quality reporting

- Quality metrics are reviewed monthly by Trust Board and the Executive Management Team, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The integrated performance report covers substantial quality information and is reported to the Board and Executive Management team. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversees the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Director of Nursing and Quality and Director of Finance co-chair the Trust-wide Improving Clinical Information and Information Governance Meeting. 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.
- 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

- 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 Improving Clinical Information and Information Governance Meeting with 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

- Behaviours and skills are an essential part of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for Information Governance and the Trust's clinical information systems (RiO, SystmOne and a small number of additional systems) 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 Executive Management Team meeting 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 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 are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

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. During 2017/18, an Internal Audit of data quality baseline assessment within the Trust found significant assurance.

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 the 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 the 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 Board Assurance Framework (BAF) 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 BAF 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 BAF.

Directors' appraisals are conducted by the Chief Executive with objectives reviewed and prioritised on a quarterly basis. This has provided a strong discipline and focus for Director performance. Non-Executive Director appraisals are undertaken by the Chair of the Trust.

The Trust has refined its values-based appraisal system for staff with 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. The Trust also uses values-based recruitment and selection.

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. 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 work programmes 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. It provides a Head of Internal Audit opinion each year. 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 for 2017/18 was provided by 360Assurance.

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. 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 1 April 2017 to 31 March 2018, 10 internal audit reviews were presented to the Audit Committee. Of these, there were eight 'significant assurance' opinions and two 'limited assurance' opinions in relation to General Data Protection Regulations and additional pay spend. There were no 'no assurance opinions'. These opinions and any resulting actions support the Trust in delivering an effective governance system.

The follow up review prior to submission of the Trust's Information Governance toolkit return resulted in a 'significant assurance' opinion.

The fieldwork for three remaining reports from the 2017/18 plan relating to Pharmacy procurement, IT Strategy, and staff engagement are in progress with the assurance rating 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 'limited' or 'no' assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no' assurance' reports, a follow up audit is undertaken within twelve months.

The Head of Internal Audit's overall opinion for 2017/18 provided '**significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Trust has delivered its business in a context of significant change. During this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

Rob Webster
Chief Executive

Date: 25 May 2018

South West Yorkshire Partnership NHS Foundation Trust

Quality account | 2017/18

Contents

Part 1:
Chief Executive and Chair's Welcome

We're here to help people reach their potential and live well in their communities. This Quality Account sets out how we have done this in what has been a very difficult period for the NHS. Our strong set of values are embedded right across our services and these have helped us with the challenges we have faced.

Throughout the year, we have put safety first, always. Our 2017/18 strategic priorities featured 'quality counts, safety first', a theme that has continued through into 2018/19. Good progress has been made on the quality priorities set out in last year's report, with several notable achievements.

We delivered safe care

We welcomed the CQC back to give their independent view on the safety of our services. In December 2017 they inspected Ward 18 at the Priestley Unit in Dewsbury and found that care was safe, in line with our overall 'Good' rating. From February - April 2018, the CQC undertook our latest re-inspection, visiting a wide range of services, as well as carrying out a well-led review. Initial feedback was positive, with some areas identified that require further focus. Our results will be published in summer 2018.

We kept a strong focus on incident reporting and investigations, with more than 12,300 incidents reported during the year. The majority of these resulted in low or no harm, reflective of a positive safety and reporting culture.

We achieved key targets

We achieved targets set by our regulators and commissioners. These included access to key services, such as early intervention in psychosis and improving access to psychological therapies. We also achieved our own internally-set targets and became a better place to work, including:

- 73% of staff vaccinated against flu
- 97% of staff having an appraisal
- 85% of staff trained in the Mental Health Act
- 90% of staff trained in the Mental Capacity Act.

We embraced change and tackled challenges

- During what was arguably one of the toughest winters the NHS has ever faced, we pulled together to continue providing high quality care for local people.
- We saw an increase in the number of people needing to travel out of area, which we know affects the quality of their care. We focused our efforts on addressing this, improving internal processes and working with external partners.
- Some of our services have seen big changes with decommissioning, new contracts and models of care. Throughout this, our staff have been extremely resilient; always keeping service users at the forefront of all decisions.
- We continued to play a key role in regional and local developments. This included the West Yorkshire and Harrogate Health and Care Partnership and the South Yorkshire and Bassetlaw integrated care system.

Some things will need continuing focus in 2018/19

We are not complacent and we know that 2018/19 will be an increasingly challenging year. We will keep a strong focus on our key quality risks:

- Addressing workforce pressures – our staff survey results show more needs to be done on a number of issues, including tackling work place stress. We also need to make sure we can recruit and retain enough staff.
- Acuity and demand for services is rising – we are working with commissioners and provider partners to ensure we can continue to deliver high quality care.
- Financial sustainability – with efficiency requirements at high levels in an environment of reducing income.
- Out of area placements – which reached record levels at the end of 2017/18.

At the same time, we must focus our efforts on quality improvement, and our new campaign, #allofusimprove, will help to empower people to take action where they see something that can be improved. We are concentrating on patient safety, experience of care, and operational excellence.

These are reflected in our new three-year Quality Strategy, which was approved in March 2018 and sets out our quality ambitions for the years ahead. As part of this, achieving our 2018/19 quality priorities will be crucial; these have been developed by listening to a wide-range of people and using their feedback to help inform our plans.

This report sets out how we will continue to achieve our mission and live our values, while putting safety first, always.

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 NHS Improvement, 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: 25 May 2018

Chair: Angela Monaghan

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 2018/19 and provide a series of statements of assurance from the Board on mandated items, as outlined in the 'Detailed requirements for quality reports 2017/18' (www.gov.uk/NHSi).

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has used feedback collated through the year from engagement events, feedback from regulators and stakeholders and staff and service user experience feedback, to inform our quality priorities for the coming year. Against each of our quality priorities we've set ourselves measures for success. The measures are reviewed and refreshed each year to make sure we're adapting to both local and national intelligence, and progressing against our aim to move from '***good to outstanding'***.

Our approach to quality improvement

Our Trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values.

Our mission and values

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

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

Quality is the organising principle for our services. It is what matters most to people who use services and what motivates and unites everyone working in health and care services. The Trust's quality strategy, approved at Trust Board in March 2018, sets out a vision for the organisation and identifies key strategic objectives and aspirations to build on our strong foundation and further improve the quality of our services on our journey to be outstanding.

We know that to provide high quality person centred care we must be a well-led organisation committed to delivering safe, effective, responsive and caring services.

In SWYPFT we define quality as the achievement or surpassing of best practice standards and describe this as a "*quality counts, safety first*" approach.

To us this means

Safety: people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned.

Effective: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Caring: staff involve and treat people with compassion, dignity and respect.

Responsive: services respond to people's needs and choices and enable them to be equal partners in their care.

Well-led: an organisation that communicates well, is open and transparent, works together and in partnership with local people and communities, and is committed to learning and improvement.

Throughout 2017/18 we have taken time to further develop alignment of our strategic objectives, priorities and programmes, with quality initiatives and we will use these as a framework to focus improvement, innovation and monitor assurance.

As part of our strategy, against each quality domain, we have set out a number of objectives, some of which are aspirational, and may take 2-3 years to achieve. To realise the objectives we have identified a number of quality improvement projects, with a specified timeframe for delivery. The progress against the projects will be revisited bi-annually, reviewed and where necessary, amended to ensure we make the required progress.

The timescales for each of the projects vary, depending on the availability and complexity of the improvement. All new quality improvements that are not already in development will require a project plan, with identified delivery and outcome measures so progress can be monitored. The new projects will need to adhere to our commitment to engagement and involvement. The projects that have been identified for Year 1 will be monitored as part of the quality account process for 2018-19. The remaining projects will be monitored via the quality account in future years. Progress reports will be provided into Operational Management Group prior to being reported to Clinical Governance & Clinical Safety Committee.

Within our Quality Strategy we describe an approach to the delivery of change based on the NHS Change Model. Through this we ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

In 2018/19 we will focus on the development of skills for improvement throughout our Trust, working with our local Academic Health Science Network (AHSN) and others to build capacity and capability for change. Our innovation hub will mature, which supports every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

We are planning to introduce a quality assurance and improvement 'self- governing' assessment and accreditation model, which will provide a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model will provide a context for a dialogue on self-governance and self-evaluation. As a series of methods and tools, it will help map the relationships between quality assurance and quality improvement and a continual source of evidence for teams to inform them how well they are performing (in relation to quality). As part of this initiative we will develop an accreditation scheme that will be underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore we have enhanced our current system to include a Clinical Governance Group. This group, supplemented by our own internal inspection programme, provides a key monitoring and escalation route for action to maintain and improve quality.

We learn through a robust clinical audit programme and we participate in Research and Development with links to universities and Academic health science Networks (AHSN). We also contribute to and learn from external benchmarking and reporting initiatives including the national confidential enquiry and CQC inspection. We have an active programme of quality monitoring visits, which include our Non -Executive Directors and commissioning colleagues, to all our operational areas, from which we derive significant learning and quality assurance. We remain committed to ensuring that compliance is achieved through a focus on improvement.

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is chaired by a Non- Executive Director, with the Director of Nursing and Quality as executive lead and amongst others includes the Medical Director as a member. This committee reports directly to Trust Board.

We report on over 20 different quality indicators in our integrated performance report, including friends and family test results, infection prevention, serious incidents, safer staffing, pressure ulcers, CQUIN performance and complaints. Each of these has a specific 'stretch' target that reflects improvement in quality, and can be viewed by team, service and trust-wide. This enables us to evidence the return on our investment in quality.

We believe strong clinical leadership, supported by opportunities for innovation and robust governance arrangements will help us deliver a culture where high quality services will flourish. Through the implementation of the #allofusimprove campaign we aim to make quality everyone's business. We will achieve this by focusing on strong staff engagement and involvement, increasing the resources that are available to assist staff to make the improvement, creating a culture for nurture and learning, led by our partnership of clinical, operational and governance management teams.

Our quality priorities – summary of performance in 2017/18

Throughout 2017/18 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 2017/18'.

Below is a summary of our performance against 2017/18 quality priorities:

	No. of priorities	RAG rated summary of performance
Safe	8	6 rated green, 2 rated amber, 0 rated red
Effective	7	7 rated green, 0 rated amber, 0 rated red
Caring	10	7 rated green, 2 rated amber, 1 rated red
Responsive	4	2 rated green, 0 rated amber, 2 rated red
Well Led	3	3 rated green, 0 rated amber, 0 rated red
Total	32	**26 rated green, 4 rated amber, 3 rated red,**

We have achieved 81.25% of the goals we set for ourselves, came within 10% of achieving 12.5% of these goals and did not achieve 6.25%. The full details of our performance can be found on the table on pages 36 – 40.

Quality risks

Key risks will be mitigated in line with our risk management strategy and risk appetite. This will be done through detailed action planning to underpin implementation

Area of focus	Sample of actions underway
Workforce pressures	• Workforce plan being implemented following revised strategy • Focusing on wellbeing and engagement, recruitment and retention (participating in NHS Improvement's support programme)
Acuity and demand pressures	• Successfully implemented waiting list initiatives, with more underway • Extra focus on hotspots such as CAMHS and inpatient wards • Continued focus on serious incident reporting, investigations & learning • Greater partnership working with local partners, e.g. Wakefield autism pathway and work across West Yorkshire and Harrogate • Ongoing discussions with commissioners
Financial sustainability in a changing environment	• Enhanced quality impact assessment process introduced • Maintaining focus on quality improvement • Working with NHS Improvement on a financial improvement plan and delivering challenging cost improvement programmes
Out of area placements	• Improved internal controls • Focusing on gatekeeping and flow • Developing a single bed-base across West Yorkshire Mental Health Services Collaborative

Quality priorities 2018-19

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED (Care Quality Commission) as a framework to organise our quality improvement priorities. It is important to note that some of the projects span more than one quality domain and for ease they have been placed with the 'most relevant' domain, for example, CARING - Customer service improvements contains an action to improve the complaint wait times, which will impact on the RESPONSIVE domain

Below is a list of quality priorities that the Trust has identified in our quality strategy 2018/19.

We triangulated feedback collated through the year from engagement events, feedback from regulators and partner organisations, carers, service user feedback and staff feedback to identify our quality priorities for 2018/19.

The table below provides a summary of our improvement plans. Progress against key performance indicators will be monitored through our monthly Integrated Performance Report at board.

SAFE- people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned

Quality domain – Safety					
Quality improvement project	**What we will do**	**Area applicable to**	**How progress will be monitored**	**Outcome**	**Timeframe**
Improving physical health in mental health Strengthen the physical healthcare response for people with mental health problems & learning disability	Routinely undertake physical health assessment and treatment for people with serious mental illness	Trust-wide adult, inpatient and community teams	CQUIN performance measures CQUIN group will monitor progress and report into operational management group	100% CQUIN measures will be achieved in each business delivery unit	**March 2019**
	Revise our strategy for improving the physical health care of people with serious mental illness & Learning Disabilities (LD) across the Trust. Strategy will cover how we roll out Recognition 7 assessment of medical problems in psychiatric setting (RAMPS)and Early Warning Signs (EWS)	All services that have people on Care Programme Approach (CPA)	Strategy development will be overseen by Executive Management Team (EMT)	Updated physical health strategy in place with action identified	**March 2019**
Staffing initiatives Staffing establishments across Trust to be reviewed and improved. Agency costs to be reduced for medical staffing	Review ward establishments following NHS Improvement CHPPD analysis of staffing figures Review safer staffing in the community with a view to developing a community safer staffing tool Align safer staffing initiatives with the new Trust workforce strategy Develop a medical	Trust-wide inpatient areas and community teams	Project plan developed & progress against planned objectives to be monitored via the safer staffing group and operational management group	Staffing establishments reviewed and updated. Implementation of new professional roles	**March 2019**

	staff bank Implement our international nurse recruitment plan Extend and maximise functionality within our current e-rostering system Development of new roles for nurses and allied health professionals				
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs, both personal and financial associated with patient safety incidents	Implement safe wards and reduce restrictive interventions We aim to reduce the total number of prone restraints across our services	Mental health and learning disability inpatient services	Sign up to safety project will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year (2019-21)	**5% r**eduction in prone restraints lasting more than 3 minutes by 2020 Downward trend in use of seclusion across the Trust by 2021	**March 2021**
	We will implement human factors training for a selection of staff across the Trust (patient safety team and clinical representatives from each BDU)	Trust-wide	Access & attendance at training will be monitored via the Patient safety group	Number of people attending Human factors training and implementing changes in practice	**March 2019**
	Expand programme of safety huddles over the next 12 months	Safety huddles targeting key risks are established in all services	Progress through will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year	Increase in the number of people trained to implement safety huddles Increase in number of teams who are using safety huddles at team level Collation of information to demonstrate impact of safety huddles on patient safety incidents	**March 2021**

Suicide prevention	Implement actions from Suicide Prevention Strategy	Trust-wide services	Progress against planned objectives monitored by the suicide prevention group	Reduction in suicides by 10% across the population serviced by SWYPT and 75% in targeted areas using a zero suicide philosophy	**March 2022**
Improving our environments	Improve our clinical environments, ensuring they are fit for purpose and services are supported by facilities/estates	Inpatient services	Progress against planned objectives	95% compliance rate for all IPC audits 100% of environmental audits have action plan 100% of inpatient areas have a ligature assessment completed within the last 12 months Response rates for time a priority job is logged and responded to by estates (TBC)	**March 2019**
Safeguarding We will strengthen our safeguarding offer by undertaking a range of activities	Further embed human trafficking agenda principles of 'Making Safeguarding Personal' Enhancing clinical records with additional safeguarding information strengthen and improve our partnership relationships, Host an external facing safeguarding conference	Trust-wide services	Progress against planned objectives monitored by the strategic safeguarding group	Outcomes will be developed by project leads for each specific quality improvement project	**March 2019**

EFFECTIVE: we will achieve good outcomes with people based on best available evidence

Quality domain – clinical effectiveness					
Quality improvement project	**What we will do**	**Area applicable to**	**How progress will be monitored**	**Outcome**	**Timeframe**
Policy & procedures Review of governance process to support policy & procedures, in support of reducing clinical variation	We will review our policy guidance document We will review the governance system for development, authorisation, dissemination, and implementation of policies and procedures	Trust-wide services	Progress against objectives Monitored by EMT	Revised policy & procedures governance process	**March 2019**
Outcome measures Introduction of outcomes tools to measure clinical effectiveness and improved patient experience.	Identification of outcome measures for use at both local and Trustwide level Development of systems and processes to support implementation	Trust-wide services	Project plan to be developed Monitored by EMT	Identification of outcomes measures for local and Trustwide implementation Reportable outcomes measures Ability to monitor clinical variation	**March 2020**
NICE guidance System to support the implementation of NICE guidance to support and guide clinical practice	Undertake baseline assessments of NICE guidance Develop action plans to address non compliance Undertake quality improvement to address risks /gaps Report gaps in provision to clinical commissioning groups	Trust-wide services	Progress against planned objectives Monitored by NICE strategic overview group	Quarterly key performance report per BDU on NICE activity Gaps in compliance identified in report	**March 2019**
Support for the workforce Launch the next phase of embedding our values, focusing on translating values	Clinical supervision Monitoring of access to clinical supervision for registered professionals. Gap analysis and effective action to	All staff in clinical areas	Workforce performance wall will be used to monitor performance. Supervision group will oversee the quality improvement	To maintain or improve KPI - 80% of clinical registered staff receive clinical supervision Establish standards for	**March 2019**

into behaviour	address. Set standards for managerial supervision for all staff Update supervision policy to reflect updated standards Develop support structure and mechanisms (debrief and supervision)		work and report into Clinical Governance Group	management supervision Updated supervision policy	
	Appraisal Launch the next phase of embedding our values, focusing on translating values into behaviours Bring forward appraisal timescale to expedite strategic objectives being cascaded throughout the organisation	All staff in clinical areas	Workforce performance wall will be used to monitor performance Workforce group to monitor progress	To achieve KPI appraisals across the Trust	**March 2019**
	Promote the role of freedom to speak up guardian across the Trust	Trust-wide services	FTSU reports to Board Quality monitoring systems, i.e. staff survey	Continued improvement in FTSU role	**March 2019**
Electronic record system Implementation of new mental health clinical record system by 2019	Build greater effectiveness into standard templates co-designed with clinicians	All staff in clinical areas	Progress against planned objectives monitored by Transformation Board	Key priority programme. Monitored by Transformation board.	**March 2019**
Effective care pathways in mental health services	Care pathway development – Personality disorder pathway	Staff in relevant clinical services	Progress against project objectives	Key priority programme. Monitored by Transformation board.	**March 2020**
Clinical record keeping	Improve quality of clinical record keeping, i.e. service user voice, assessments, care plans and risk assessments Review standards for assessments, care plans and risk assessments Monitor adherence to standard through	All staff in clinical areas	Progress against record keeping standards Monitored by clinical governance group	95% compliance with clinical record keeping standards relating to service user voice, assessments, care planning and risk assessments.	**March 2021** Trajectories will be established for each year.

	audit and quality monitoring Improving co-production Capturing service users race				

CARING: we will involve and treat people with compassion, dignity and respect

Quality domain – Experience					
Quality improvement project	**What we will do**	**Area applicable to**	**How progress will be monitored**	**Outcome**	**Timeframe**
Staff experience & well being	Monitor and implement actions of staff health and well- being plan Whistle blowing – timely response times Improving staff satisfaction and wellbeing	Trust-wide services	Staff Feedback Baseline assessment and planned trajectory. KPI in IPR Monitored by the staff wellbeing group	80% of staff recommend the Trust as a place for care and treatment Improved scores in key areas on national staff survey and local well- being survey	**March 2019**
Patient experience	Scale up our patient experience volunteer programme Continue to enhance our patient experience reporting, ensuring that data is triangulated at all levels in the organisation Exit questionnaires on inpatient services to understand the quality of their experience during admission Use feedback from student placements to enhance patient experience	Trust-wide inpatient services	We will measure the percentage of people who are extremely likely/ likely to recommend the service to their friends and family. We will review the actions taken in response to service user experience feedback	Forensic 65% Learning disabilities 85% CHS 98% Mental health services 85% CAMHS 75% Baseline assessment of current satisfaction on inpatient wards – then set trajectory of improvement for year 2	**March 2019**

Customer service improvements	Implement our revised approach to complaints We will improve the complaint response times Update customer service report	Trust-wide services	Progress against planned objectives Integrated Performance Report Customer Service Report Monitored by clinical governance group	Local procedures for managing complaints Less referrals to Ombudsman Monitor length of time from complaint to report < 40 days year 1 & 25 days year 2	**March 2020**
Nursing strategy	Complete the nursing strategy (2015-18) action plan and redevelop the strategy in line with national initiatives and priorities Introduce the HEE/NIHR Integrated Clinical Academic Internship scheme for nursing staff	Trust-wide nursing staff	Monitor progress against KPI's set in the nursing strategy	Revised nursing & AHP strategy with clear objectives and targets.	**March 2019**
Allied health professionals strategy: Into action	Implement objectives for 18/19	Trust-wide allied health professionals	Monitor progress against objectives/ KPI's Monitored by allied health professional network	Revised nursing & AHP strategy with clear objectives and targets.	**March 2019**
Medical strategy	Implement objectives for 18/19	Trust-wide medical staff	Monitor progress against objectives/ KPI's Monitored by medical network	Implementation of strategy	**March 2019**
Scale up our patient experience volunteer programme	Achieve 70 new volunteering opportunities within the Trust	Trust-wide	Monitor progress against a baseline in IPR	Increase in number of volunteers	**March 2019**

RESPONSIVE: we will respond to people's needs in a timely way

Quality domain – Clinical effectiveness					
Quality improvement project	**What we will do**	**Area applicable to**	**How progress will be monitored**	**Outcome**	**Timeframe**
Transitions of care	Extend our work on transition pathways across Trust services Work with external partners to improve transitions of care	Trust-wide services	CQUIN group will monitor performance against CQUIN requirements	Achievement of CQUIN performance measures	**March 2020**
Improve access to CAMHS service	Recruit to CAMHS vacancies so that the revised pathways we have implemented work optimally, ensuring we can sustainably meet demand Implement an all-age liaison service to further improve responsiveness out of hours Secure a commitment from commissioners to fully meet demand for adult autism services Early warning of delays e.g. waiting times – keep people informed	CAMHS services	CAMHS waiting time performance is monitored via EMT IPR , with a bi monthly report into CGCSC	Improvement in CAMHS waiting times	**March 2020**
Continue implementing equality & inclusion strategy action plan	Continue to implement the 4 objectives of the strategy	Trust-wide	Monitor progress against objectives/ KPI's Monitored by Equality Strategic Forum	Implementation of E&I strategy objectives	**March 2020**
Learning disability service wait times	Reduce wait times in services for people with LD	Learning disability services	Waiting time performance is monitored via EMT IPR , with a bi monthly report into CGCSC	Improvement in LD waiting times	**March 2020**
Out of area beds	Reduce the number of days people spend in	Inpatient areas	Out of area bed reduction is a priority programme	Reduction in number of days people spend in	**March 2019**

	out of area placements		and will be monitored by EMT	out of area placements	

WELL LED: we will work in partnership and learn from our mistakes

Quality domain – Safe, operational excellence &experience					
Quality improvement project	**What we will do**	**Area applicable to**	**How progress will be monitored**	**Outcome**	**Timeframe**
Implementation of a quality accreditation scheme	Roll out the project across the Trust	Trust-wide clinical services	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	Achievement of milestones that leads to successful implementation of scheme	**March 2021** Trajectories will be established for each year.
Quality dashboard development (ongoing development of quality metrics)	A quality dashboard will be developed to support the quality scheme	Trust-wide services	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	A dashboard will be available for staff	**March 2021** Trajectories will be established for each year.
Development of a quality improvement toolkit	Development of a quality improvement toolkit and website Increasing 'do and share' improvements	Trust-wide services	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	Toolkit developed and available for staff to use Monitor use of toolkit in do and share improvements	**March 2019**
Learning lessons across the Trust	Develop a 'learning from feedback' SO WHAT framework, strengthening our existing processes including complaints, serious incidents, patient experience and audit information	Trust-wide	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	Framework developed and implemented	**March 2019**

The measures identified in the Quality Priorities 2018/19 (above) will be reported and monitored in the following ways throughout the year:

1. Monthly reporting of key performance measures in the Integrated Performance Report to Executive Management Team

2. Bi-monthly reporting of all quality account measures into the Clinical Governance and Clinical Safety Committee.

3. Monthly and/or quarterly reporting into Clinical Governance Group (CGG)

4. To Clinical Commissioning Groups via Quality Board meetings.

Care Quality Commission (CQC) inspection

Care Quality Commission (CQC) inspection

During two weeks in March 2018, CQC undertook unannounced visits to six of our core services. All of these services had previously received either 'must' and 'should' do actions from previous CQC inspection visits. The aim of the visits was to look at whether our teams and services had satisfactorily addressed the outstanding issues. The core services visited were as follows:

- Acute wards and PICU for working age adults
- CAMHS
- Forensics
- Community LD and autism
- Community mental health services
- Inpatient LD service

As an organisation we welcomed the CQC visit to our core services as an opportunity to show them the progress we have made in improving the quality and safety of our services. We also acknowledge that in some areas further improvements are needed and therefore welcome the role of CQC as an external body and our regulator to provide feedback on our achievements and about what we can do better.

In April 2018, CQC conducted their announced well-led review of our organisation over a three day period. This included interviews with key individuals, a number of focus groups and looking at information files of live cases in relation to such things as ongoing complaints and serious incidents. We did receive some verbal feedback at the end of the well-led review which provided positive feedback and some identified areas for improvement.

The head of inspection for the well led review stated that it was a privilege and a pleasure to walk into such a welcoming organisation. Then explained that there are areas where they have requested further information before determining their view. We submitted further information to assist their understanding of our position.

They then reported a number of very positive findings:

- Strong engagement, both internal and external
- Great culture, open and honest with a clear focus on the individual
- Excellent DBS system – the best they have seen with a genuine focus on safety
- Strong senior management visibility and with an open and approachable style
- Very strong strategy development that is taken very seriously by executive team

- Good clinical and internal audit processes
- Really good serious incident and mortality review process
- Good leadership and management development and succession planning

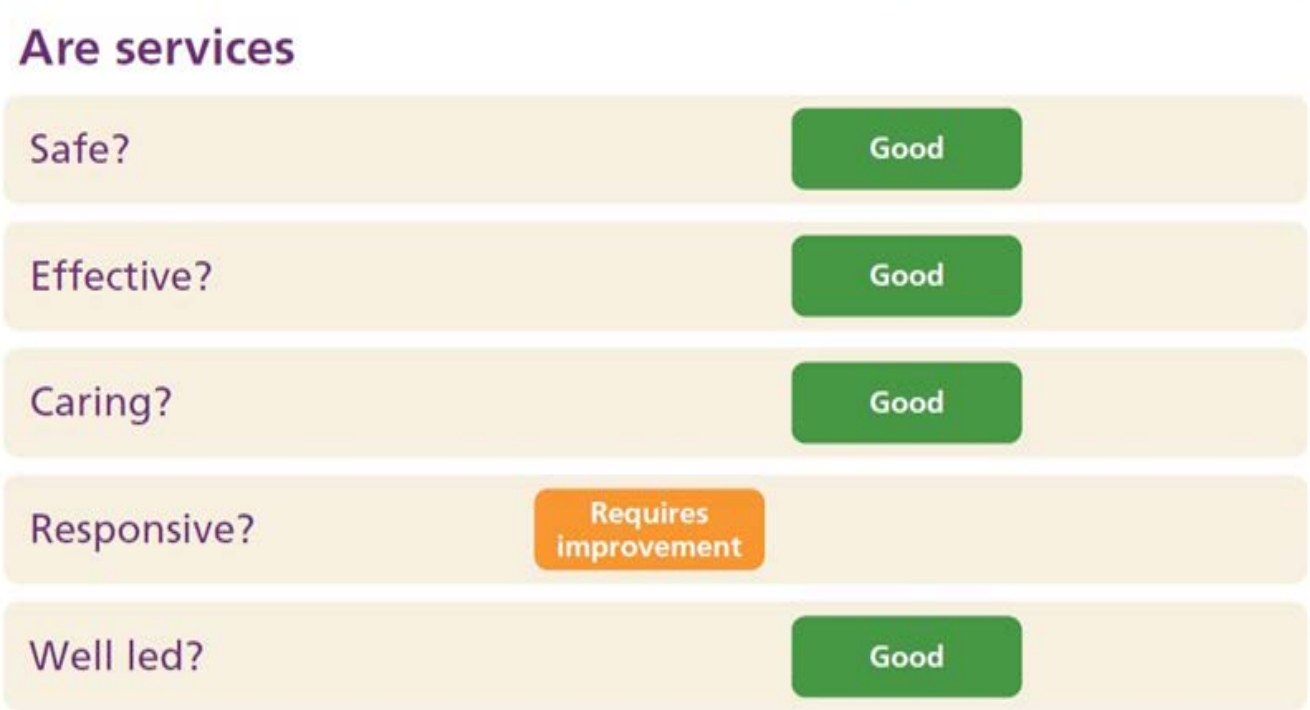
In closing they said that it was great to see such friendly teams, open to new ideas and challenge, in services where people “had a smile on their faces”.

As yet we have not received our reports and are expecting these around May/June 2018. On receipt of our reports we will be given a ten day period to make comment on any factual inaccuracies before the reports are publicised.

We will develop action plans to address any areas the CQC raise as concerns and share the good practice across the Trust.

SWYPFT CQC ratings charts - April 2017

Our existing ratings are on display and our website.



Care Quality Commission

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Care Quality Commission have inspected our services.
They have given us an overall rating of GOOD.

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

We will continue to improve as we aim to be outstanding.

With all of us in mind.

Part 2.2 – Statements of assurance from the board

Review of services

During 2017/18 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 98 relevant health services. South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 98 (100%) of these services.

The income generated by the relevant health services reviewed in 2017/18 represents 100 percent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2017/18.

Participation in clinical audit

During the 2017/18 Ten (10) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2017/18 South West Yorkshire Partnership NHS Foundation Trust participated in 10/10 (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 SWYPFT was ***eligible to participate*** in, and ***did participate in*** during 2017/18 are as follows:

National Clinical Audits SWYPFT was eligible to participate in during 2017/18	1) National Chronic Obstructive Pulmonary Disease (COPD) 2) Sentinel Stroke National Audit (SSNAP) clinical audit 3) National Audit of Intermediate Care (NAIC) 4) National Audit of Psychosis 5) National End of Life Care Audit 6) UK Parkinson's Audit 7) POMH 1 & 3: Prescribing high dose and combined antipsychotics 8) POMH 17a: Use of depot / LA antipsychotic injections for relapse prevention 9) POMH 16a: Rapid tranquillisation 10) POMH 15b: Prescribing valproate for bipolar disorder
National Confidential Inquiries SWYPFT was eligible to participate in 2017/18	National Confidential Inquiry into Suicide and Homicide by people with mental illness

National clinical audit programme 2017/18

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 2017/18, 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 the 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
National Chronic Obstructive Pulmonary Disease Audit (COPD)	37 audits submitted in June 2017	The audit will produce site level reports following the close of the data collection period, and national reports will be published later in 2018
Sentinel Stroke National Audit Programme (SSNAP)	Ongoing data collection 154 cases received so far between April and July 17. National reports reported 3 times per year	SSNAP summary report received for April to July 2017. Quarterly reporting from SSNAP next reporting periods are August – November 2017, December 2017 – March 2018. Reports always a quarter behind
National Audit of Intermediate Care (NAIC)	This is a benchmarking audit so it is not possible to quantify	National report produced December 2017
National Audit of Psychosis	253	NCAP local process flowchart states the final data sets, local and national reports to be sent to the Trust in June 2018
National End of Life Care Audit	Registration completed for NACEL in February 2018	Timelines for NACEL: Organisational level audit - May guidance issued, June Data collection opens, October data collection closes
UK Parkinson's Audit	40	Summary audit produced March 2018
POMH 1g and 3d: Prescribing high dose and combined antipsychotics	235	POMH published the Trust report on the supplementary audit in October 2017
POMH 17a: Use of depot / LA antipsychotic injections for relapse prevention	177	POMH published the Trust report on the baseline audit in January 2018
POMH 16: Rapid tranquillisation	65	Topic 16a-POMH published the Trust report on the baseline audit in July 2017
POMH 15b: Prescribing valproate for bipolar disorder	103-not confirmed without report	Report yet to be published

The reports of ten (10) national clinical audits were reviewed by the provider in 2017/18 and South West Yorkshire NHS Foundation Trust intends to take the following actions to improve the quality of health care 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 BDU governance group
- Outcomes from clinical audits are reported to the Clinical Governance and Clinical Safety Committee in the annual report.

National confidential inquiry (NCI) 2017/18

The national confidential inquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
National Confidential Inquiry into Suicide and Homicide by people with mental illness	27	24 (89%)	3 questionnaires continue to be processed

Local clinical audit

During 2017/18 the Clinical Audit and Practice Evaluation (CAPE) prioritised plan had a total of 82 clinical audit projects listed. The reports of 58 local clinical audits were reviewed by the provider in 2017/18. There are 58 projects completed, 15 projects in progress and 9 projects have either been deferred into 2018/19 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 the business delivery unit. Areas of concern 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 BDU Governance Group.
- Outcomes from audits are reported to the Clinical Governance and Clinical Safety Committee in the bi annual report.

Participation in clinical research

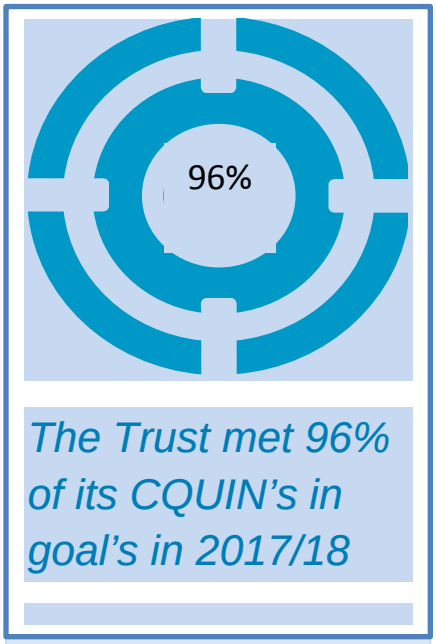
The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee 648.

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at www.swyt.nhs.uk/ performance reports.



An overall total of £4,235,986 was available for CQUIN to SWYPFT in 2017/18 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,173,579 (96%) is expected to be received for the associated payment.

SWYFT have a number of other Contracts with quality payments

Leeds Community Hospital	£29,240	100%
Barnsley CCG Associates	£13,880	100%
NHSE Vaccination & Immunisation Screening	£10,601	100%
Wakefield CCG Angel Lodge	£5,808	100%
Wakefield CCG TB service	£2,878	100%

SWYPFT achieved 100% of these contracts which resulted in an additional £62,407 of income.

In 2016/17 an overall total of £4,493,876 was available for CQUIN to SWYPFT and a total of £3,881,121 (86%) was expected to be received for the associated payment. By comparison an overall total of £4,720,416 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 £3,660,958 (78%) was received for the associated payment.

Over the past 3 years SWYPFT has increased the percentage achievement for CQUIN's from 78% to 96%.

A summary of CQUIN achievement for 2017/18 are outlined on the tables below:

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Wakefield, Kirklees, Calderdale	**Mental health and learning disabilities**	Improving the health and wellbeing of NHS Staff	£279,352	67%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£279,352	89%
		Improving Services for People with Mental Health needs who present to A&E	£279,352	100%
		Transitions out of Children & Young People's Mental Health Services *	£279,352	100%
		Preventing Ill Health by Risky Behaviours - alcohol & tobacco	£279,352	96%
		Risk Reserve	£ 465,587	100%
		STP engagement	£465,587	100%
		TOTAL	**£2,327,936**	**94%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Secure services	**Low & medium secure services**	MH2 Recovery Colleges for Medium and Low Secure Patients	£284,546	100%
		MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services	£284,546	100%
		TOTAL	**£569,091**	**100%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Barnsley	**Mental health, learning disability and community health services**	Improving the health and wellbeing of NHS Staff	£127,681	67%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£170,190	89%
		Improving Services for People with Mental Health needs who present to A&E	£170,190	100%
		Transitions out of Children & Young People's Mental Health Services *	£170,190	100%
		Preventing Ill Health by Risky Behaviours - alcohol & tobacco	£127,681	94%
		Risk Reserve	£255,310	100%
		STP engagement	£255,310	100%
		TOTAL	**£1,276,552**	**95%**

*please see section 3 where you will find an explanation of our performance against these CQUIN's.

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
- Treatment of disease, disorder or injury

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

CQC breach of conditions of registration : In December 2017, CQC issued SWYPFT with a fixed penalty notice fine for breach of conditions of registration. This matter was in relation to the transfer of two wards from Mount Vernon to wards 35 and 36 at Barnsley Hospital Foundation Trust (BHFT) that occurred in September 2017. CQC deemed that whilst we had submitted an application to update our conditions of registration to incorporate the transfer of the wards to BHFT, patients had been moved into wards 35 and 36 before the application process had been

completed and therefore issued us with the fine. This matter has been satisfactorily dealt with and no further actions will be taken against SWYPFT in relation to this issue.

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2017/18.

South West Yorkshire Partnership NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during 2017/18.

NHS Number and General Medical Practice Code Validity

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
The percentage of records in the published data which included the patient's valid NHS number was:

- 99.7% for admitted patient care
- 100% for outpatient care and
- N/A for accident and emergency care.

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

- 99.9% for admitted patient care;
- 99.9% for outpatient care; and
- N/A for accident and emergency care.

Information Governance Toolkit attainment

South West Yorkshire Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 is 66% and is graded green.

Clinical Coding accuracy

Our latest audit of clinical coding showed 97% 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.

Quality of data

Improving data quality remains one of the Trust's quality priorities. There was continued focus in 2017/18 on improving the quality of clinical record keeping (Three priority areas were identified and are being monitored on an ongoing basis – this is likely to be reviewed during 2018/19 through the implementation of the new clinical information system for Mental Health services). This underpins the delivery of safe effective care and assures the Executive Management Team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Trust will take the following action in 2018-19 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, NHS Improvement, CQC, the Department of Health, Commissioner, partners and the Members' Council. The Trust also publishes data via its Integrated Performance report which includes a wide range of quality and performance measures.
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 2018-19 data quality improvement programme and will provide progress updates to the executive management team. BDUs will develop and deliver individual BDU-level improvement plans.
Innovation for quality	The Trust are currently undertaking a large transformation programme to implement a new mental health clinical information system and are working to ensure innovation for quality is embedded within this. The Trust will be moving onto the new system (SystmOne for Mental Health) during 2018/19 and will continue to optimise our clinical information systems 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

2.3.1 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%					
		2017/18	**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 2017/18	97.7%	95.5%	96.9%	97.2%	96.9%
		NHS England (NHSE) data 2017/18	96.7%	96.7%	95.4%	95.5%	96.1%
		NHSE provider lowest performance (2017/18)	71.4%	87.5%	69.2%	68.8%	69.2%
		NHSE provider highest performance 2017/18	100%	100%	100%	100%	100%
		SWYPFT 2016-17	96.9%	97.8%	97.4%	97.5%	
		SWYPFT 2015-16	98.66%	97.98%	95.64%	97.44%	

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 NHS Digital.

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 & Quality, 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.

2.3.2 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					
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	**2017/18**	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
		SWYPFT 2017/18	98.4%	96.9%	96.9%	99.6%	98%
		NHS England (NHSE) data 2017/18	98.7%	98.6%	98.5%	98.7%	98.6%
		NHSE provider lowest performance 2017/18	88.9%	94.0%	84.3%	88.7%	90.1%
		NHSE provider highest performance 2017/18	100%	100%	100%	100%	100%
		SWYPFT 2016-17	96.9%	99.3%	99.3%	99.3%	
		SWYPFT 2015-16	95.81%	97.29%	96.04%	98.32%	

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.

This information can be extracted directly from the electronic record system and is done so by counting all admissions to adult acute/psychiatric intensive care unit, we then look to see if there was a contact that took place within 72 hours of admission and where the contact had an activity code of ‘gatekeeping’ – this is then counted as gatekept.

Data is clinically validated before it is submitted to NHS Digital.

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.

2.3.4 Readmission rates

Indicator	NHS Outcomes Framework Domain	SWYPFT data						
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
The data made available to the National Health Service trust or NHS foundation trust by NHS Digital 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%	9.8%	9.8%

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

90.2% of people were not readmitted.

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 NHS Digital.

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.

Please note: This information is not made available to SWYPFT by NHS Digital (NHSD). NHSD monitor re-admissions within 30 days, in SWYPFT we monitor re-admissions within 28 days and hence the data is not comparable.

2.3.5 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>Indicator</th><th>NHS Outcomes Framework Domain</th><th>SWYPFT 2017 Score (out of 10)</th><th colspan="2">National 2017 score</th></tr>
<tr><td rowspan="11">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="11">2: Enhancing quality of life for people with long-term conditions

4: Ensuring that people have a positive experience of care</td><td>7.9</td><td colspan="2">National comparison
About the same as other trusts nationally
(CQC website)</td></tr>
<tr><td rowspan="2">SWYPFT 2016 score</td><td colspan="2">National 2016 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>7.5</td><td>8.5</td><td>6.8</td></tr>
<tr><td rowspan="2">SWYPFT 2015 score</td><td colspan="2">National 2015 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><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 actions to improve this percentage and therefore the quality of its services: triangulating this information with other sources of patient and staff experience feedback in order that we can successfully focus our action.

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

Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures accuracy of data. Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS. This data has been prepared on 20th April 2018, and it should be noted that the reporting rate to NRLS will increase.

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 (%)**
17-18 Q1	1474	3	0.20%	10	0.67%
17-18 Q2	1586	7	0.44%	11	0.69%
17-18 Q3	1494	8	0.53%	14	0.93%
17-18 Q4	1210	4	0.66%	8	0.33%
Totals:	5764	22	0.38%	43	0.74%

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

In 2017/18, the Trust uploaded a total of 5764 patient safety incidents to the NRLS, compared with 6556 reported in 2016/17's Quality Accounts. 95% of the 5764 incidents resulted in no harm or low harm, which is consistent with 2016/17.

The Trust reported a total of 65 severe harm and patient safety related death incidents in 2017/18, compared to 57 incidents in 2016/17 (as at 20/4/17).

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has remained the same (0.38% of all uploaded patient safety incidents) when compared with 2016/17. The number patient safety related deaths has increased to 0.74% of all uploaded patient safety incidents compared with 0.48% in 2016/17.

There has been an increase 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 2018 will have been reviewed and uploaded to the NRLS at the date of the report.

2.3.7 Learning from deaths

The Serious Incident Framework (2015) forms the basis of the trust policy which guides our staff about the reporting, investigating and learning from incidents, including deaths. The Learning from Deaths policy, which was approved by our Board of Directors in September 2017, further enhances the processes of investigation and learning.

During 2017/18 2884 of South West Yorkshire Partnership NHS Foundation Trust patients died. This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number, the Trust was not the main provider of care at the time of death.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 745 in the first quarter;
- 675 in the second quarter;
- 725 in the third quarter;
- 739 in the fourth quarter.

By 20 April 2018, 167 deaths met the Learning from Healthcare Deaths review criteria. 55 were subject to case record reviews and 73 were subject to investigations. In addition, 39 deaths were certified. A further 313 deaths were reported on Datix which did not meet the criteria for further review.

Table 1

	Case record reviews/Structure Judgment Record Reviews	Investigations (including serious incident, service level, safeguarding, LeDeR)	Death Certified	**Total**
Quarter 1	4	12	11	**27**
Quarter 2	6	16	1	**23**
Quarter 3	17	27	18	**62**
Quarter 4	28	18	9	**54**
Total	**55**	**73**	**39**	**167**

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 16 in the first quarter;
- 22 in the second quarter;
- 44 in the third quarter;
- 46 in the fourth quarter.

Our learning from healthcare deaths policy and reports provide further information on our reporting criteria.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England Alliance, we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. The Northern Alliance are unable to report on what are described in general hospital services as “avoidable deaths” in inpatient services. This is because there is currently no research base on this for mental health services, no satisfactory definition of ‘avoidable’ and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will continue to review this decision and will continue to support work to develop our data and general understanding of the issues.

During 2017/18, we conducted 128 investigations or case note reviews.

Through these processes, the Trust has not identified any overt act or omission in care which were judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

For deaths resulting in investigations, the Trust seeks to identify if there were any root causes. The investigation process also seeks to identify care and service delivery issues which relate to systems and processes which do not have a direct impact on outcome.

Our investigations have identified 55 actions for improvement, none of which directly contributed to the death.

Our Structured Judgment Record Reviews are conducted by trained reviewers from a clinical background (e.g. medicine, nursing, physiotherapy) using an approved template. Each phase of a person's care is considered by the reviewer including risk assessment, initial review, ongoing care, in patient care and follow up/discharge.
The number of Structured Judgment Record Reviews has been limited given the length of time the policy has been in place. From the rating of phases of care for completed reviews, early emerging areas for improvement relate to risk assessment and ongoing care; however more data is required to confirm these as themes as numbers are small.

From the investigations into deaths that have been completed, there have been no root causes identified. However, we have identified 55 actions arising from care and service delivery issues, as part of our serious incident investigations, which are likely to result in improvements in practice. These actions are reported within our quarterly and annual incident management reports.

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period is outlined above.

The actions which the Trust will take during 2018/19, in consequence of what we have learnt during 2017/18 are summarised below.

Following investigations, there are many actions that are identified to improve practice. Each action is themed to enable analysis. Many actions support reducing variation in practice across the Trust. Some actions are at team level, others at Trust or service level. Some examples from the top 3 action themes are given below. Further analysis is available in Our Learning Journey reports.

- Record keeping actions focussed around clinical record keeping; completeness of records and quality of information; ensuring care plans are updated especially at transitions of care; ensuring discharge information and rationale is fully documented recorded; Recording Multi-Disciplinary Team discussions/meetings; Service user and family and carer information
- Staff education, training or supervision in relation to safeguarding advice; mental capacity act; knowledge of Caldicott guardian role and developing guidance on removing access to means of suicide
- Communication issues relating to when there are multiple teams involved with a service user; sharing care plans with GPs, raising clinical concerns and liaison with other agencies.
- Organisational systems and management issues around use of telephone systems; review processes and developing guidance on recording deaths on clinical systems

In response to analysis of apparent suicides, several work streams are underway around the following themes:

- Analysis of younger adults dying by apparent suicide
- Dual Diagnosis
- IHBTT and recent discharge
- Self- harm
- Discharged patients
- Depression

Work to support the implementation of the Patient Safety Strategy continues, including promoting awareness of human factors methodology, focussing on measurement and monitoring of safety, introducing Safety Huddles and developing learning systems. These support the wider patient safety agenda including learning from healthcare deaths.

Further evidence is needed from 2017/18 Structure Judgment Record Reviews to form judgments, as numbers to date are small.

It is not currently possible to provide an assessment of the impact of the actions which were taken by the provider during the reporting period. As our processes embed, this will be developed.

2.3.8 External audit of mandated and local indicators

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

Mandated indicators

The way the mental health mandated indicators are chosen has been updated for 2017/18. In previous years our council of members has selected the indicator from a pre-determined list, this year there is also a predetermined list of new indicators and the indicators are determined on the basis that if you report against the first one on a given list then you do this, but if you don't report the first indicator then you move to the second indicator, until you reach two indicators that you report.

Using this methodology the indicators that have been tested are:

1. **Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral**

Detailed descriptor - The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care.

Approach by external audit

- Met with the Trust's leads to understand the process from a referral to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- Evaluated the design and implementation of controls through the process.
- Selected a sample of 25 from 1 April 2017 to 31 March 2018 including in our sample a mixture of cases in breach and not in breach of the target.
- Agreed our sample of 25 to the underlying information held within RiO and patient notes.

- Recalculate the indicator presented in the Quality Accounts using data provided to us, as reported on page 34.

Outcome : the auditors found that there were 2 instances where the clock start dates were incorrect based on the patient notes and information held in RiO however the difference had no impact upon the indicator and based on testing that has been performed have issued an unmodified opinion.

2. **Inappropriate out-of-area placements for adult mental health services**

Definition: "Total number of bed days patients have spent out of area" on placements assessed as inappropriate, calculated as the average of the monthly position.

National context: Inappropriate Out of Area Placements has been mandated as an indicator for the first time this year. Due to the relatively recent inclusion in the Single Operating Framework, and so increased focus on this metric, NHS Improvement has given providers the choice for 2017/18 of reporting figures for Quarter 4 only, or for the whole year. The Trust has decided to report figures for the whole year, however, our audit is based on the Q4 position as detailed by the indicator guidance.

The indicator has a number of potentially complex judgements to assess whether an Out of Area Placement is, in fact, appropriate. We understand from NHS Improvement that over 90% of placements are reported as "inappropriate", though it is not clear whether this is due to any overall issues in reporting or identifying "appropriate" placements, or reflects the actual split of cases. However, discussions in testing across our portfolio suggest that some of this may be due to less focus on classification for the metric than just reporting overall numbers of placements.

Approach by external audit

- Met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year
- Evaluated the design and implementation of controls through the process.
- Selected a sample of 25 from 1 April 2017 to 31 March 2018
- Recalculate the indicator presented in the Quality Account using the data provided to us as reported on page 34.

Outcome: the auditors identified two cases where there was an incorrect start date based on the information held within RiO and patient notes however, as the error occurred prior to 1 January 2018, it has no bearing upon the indicator and based on testing that has been performed have issued an unmodified opinion.

Local indicator

For 2017/18 the Members Council Quality Group has agreed that the local indicator will be waiting times across Children & Young Peoples' Eating Disorder (CYP-ED) pathways

Definition: Waiting times across children & young people's eating disorder (CYP-ED) pathways.
In SWYPFT we have calculated these figures as:

		Q3	Q4
Urgent Referrals	% within 1 week	**76.47%**	**69.23%**
Routine Referrals	% within 4 weeks	**92.00%**	**94.44%**

Approach by external audit

- Met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year
- Selected a sample of 25 from 1 April 2017 to 31 March 2018
- We agreed our sample to the underlying data held within RiO and the patient notes.
- Recalculate the indicator presented in the Quality Account using the data provided to us as reported in the table above.

Outcome: the auditors found inconsistent recording of the data within the RiO system where referral received dates were not consistent within the different screens of RiO. This did not affect the underlying reporting, however meant when tied to supporting evidence there were multiple referral dates on different screens in RiO.

The auditors have made recommendations against their findings of mandated and local data testing and the Trust will put actions in place to ensure these recommendations are implemented.

2.3.9 Guardian of safe working hours

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

The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point.

The Trust appointed a senior medical representative as the Guardian of Safe Working and his 2017 Annual Report highlighted the following:

- The number of exception reports had been low during 2017, which is in line with the majority of mental health trusts. However concerns about work pressure continue to be raised in other fora by Calderdale trainees.
- How the role of the Guardian of Safe Working is communicated to the trainees has been improved throughout the year.
- Processes for addressing concerns raised by trainees have been developed.
- Although there continues to be a major concern around the number of vacancies on the on-call rotas, improvements have been made around the consistency across the Trust as to how the gaps are managed.
- The development of the Trust Medical Bank appears to be assisting in reducing the number of shifts needing to be covered by agency staff.
- Work to develop a system for monitoring the impact of vacancies from a financial point of view is on-going.

The Trust Board received the 2017 Annual Report on Safe Working Hours Doctors in Training, and confirmed their assurance that the Trust had met its statutory obligations.

2.3.10 Performance against indicators set out in Single Oversight framework

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the Single Oversight Framework (SOF)

Indicator	SWYPFT Performance Data 2017/18				
	Threshold	Q1	Q2	Q3	Q4
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	50%	89.2%	84.4%	89.5% *	*89.8%**
IAPT – Treatment within 6 weeks of referral	75%	82.3%	81.5%	90.2%	*90.7%*
IAPT – Treatment within 18 weeks of referral	95%	99.6%	99.3%	99.5%	*100%*
Admissions to adult facilities of patients under 16 years old	0	0	0	0	0
Inappropriate out-of-area placements for adult mental health services (days)	Reducing trajectory being identified	665 days	869 days	1131 days	1527** days

Note: * External audit have tested our data for Early Intervention in Psychosis – findings can be found on page 31

** External audit have tested our data for out of area placements for adult mental health services – finding can be found on page 32

We have identified out of area bed usage as a priority area of focus for the Trust and a significant amount of work has already been undertaken or is ongoing, including:

- Increased the operational focus on people who have been placed out of area. This has included:
  - Daily monitoring of patients in all beds
  - Regular communications through line management structures and as part of Trust briefing systems
  - Fortnightly Out of Area (OOA) project board meetings with one meeting per month focusing on operational issues and one meeting per month looking at all the issues – both operational and improvement
  - Weekly meetings which have focused on people who have been on an inpatient ward for more than 40 days
- Ongoing work using quality improvement approaches in order to identify the areas that require improvement and to take action to improve patient flow and minimise the need as far as possible for admission to an acute or PICU bed. This has included:
- Extensive data collection, analysis and reporting.
- Qualitative peer reviews of what has actually happened with individuals that has meant they have required an admission into an acute bed enabling consideration of the impact on people and the specific contributory factors of a case
- We have visited other Trusts to learn from their experience.
- Working with our provider colleagues across West Yorkshire to share learning and use our collective resources as part of the West Yorkshire & Harrogate Health and Care Partnership.
- Undertaking a pilot with the Academic Health Sciences Network to review patient flow and learning from the acute sector. This recently culminated in a workshop focusing on flow in Calderdale.
- Sharing good practice and learning from each other across the SWYPFT footprint.

Section 3:
Our performance in 2017/18

In this section you'll find more information about the initiatives we have undertaken to improve the quality of our services and build a culture for improvement . In 2017/18 we set ourselves a set of challenging goals. We'll take you through these measures and the work we did to improve the quality of our care.

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED (Care Quality Commission) as a framework to organise our quality improvement priorities. It is important to note that some of the projects span more than one quality domain and for ease they have been placed with the 'most relevant' domain, for example, CARING - Customer service improvements contains an action to improve the complaint wait times, which will impact on the RESPONSIVE domain

The quality initiatives we undertake against our quality priorities change from year to year, which means we are not always able to make a direct comparison of our performance against each priority each year, as we are not comparing 'like for like' and comparable data is not available. Where we are able to make comparisons across the years we have done so. We make these changes to continually strive to improve the quality of our care.

Our quality priorities are underpinned by a number of performance indicators. These include some current Key Performance Indicators and also Commissioning for Quality and Innovation goals (CQUIN). Note: the figures/ratings used in the Quality Account don't exactly correlate with achievement of CQUIN goals set by commissioners - this is because in some instances, for the Quality Account, a rounded average is taken across BDUs 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 36 - 40.

Our Trust provides a wide range of services across a number of communities. These services are commissioned from two separate commissioning groups, which are:

1. Barnsley
2. A collective group of Calderdale, Kirklees and Wakefield commissioners.

As commissioners are working for different communities the goals for each area can differ. However, as an organisation, the Trust ensures that a consistent quality threshold is applied across all service

QUALITY ACCOUNT 2017/18

Note: figures/ratings used do not exactly correlate with achievement of CQUIN targets set by commissioners - this is because for the Quality Account a rounded average is taken across BDUs and care groups rather than split down into target achievement in each care group and BDU.

Quality Domain	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
SAFE	**S1.** Improving the physical health for patients with severe mental illness (SMI) A .Cardio Metabolic Assessment and Treatment for Patients with Psychoses (in line with National Audit of Psychosis)	CQUIN performance Targets	Quarterly	Barnsley												
				Calderdale												
				North Kirklees												
				Greater Huddersfield												
				Wakefield												
	S2 B. Communication with General Practitioners	CQUIN performance Targets		Barnsley Calderdale												
				North Kirklees												
				Greater Huddersfield												
				Wakefield												
	S3 Clinical risk assessments	Develop a reporting and monitoring of clinical risk assessment	Report													
	S4 Safer staffing Trust overall Safer staff fill rates	90%	Monthly	110	111	103	113	109	112	113	115	113	117	118	116	
	Registered nurse staff fill rates	80%		110	110	100	97	91	95	100	101	97	100	98	98	
	S5 Total number of reported incidents	NA	Monthly	842	1017	971	1064	1081	867	995	993	969	1116	1113	1156	
	Total number of incidents resulting in severe harm			1	0	2	3	1	4	1	5	3	2	3	3	
	Total number of incidents resulting in moderate harm			15	16	26	20	24	14	20	20	16	26	31	22	

Quality Domain	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
SAFE	**S6** *Number of pressure ulcers attributable to SWYPFT	Trend	Monthly	27	25	30	32	31	29	16	26	29	45	29	24	29/month
	*Number of avoidable pressure ulcers	0	Monthly	0	1	1	0	1	0	1	1	0	2	0	0	
	S7 Number of falls (inpatients)	Trend	Monthly	38	52	49	39	54	46	41	43	66	40	80	61	50/month
	S8 Number of prone restraint incidents that lasted less than 3 mins (percentage of all prone restraints)	80%	Monthly	68	76	80	76	86	76	77	80	82	70	80	79	77.5
	Mental Health Safety Thermometer (MHST) – monitoring of medication omissions	Downward trend based on Q4 (15/16) performance	Quarterly	This information is no longer available												
	S9. Suicide strategy implementation	Report	Annual													
	S10 Mortality reviews	Report	Annual													

"a - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
b - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage "

Quality Domain	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
EFFECTIVE	**E1.**Improve the quality of care planning - Monitor quality elements of care planning via the clinical record keeping audit	85%	Annual													
	E2. Clinical supervision – monitor the percentage of registered staff who are accessing clinical supervision – as reported on the Trustwide database	80%	Annual										86.5%			
	.Timely assessments and reviews of care and treatment – monitoring of: Unvalidated progress notes	Downward trend	Monthly	KPI not taken forward												
	E3 Appointments that have no outcome (percentage of all appointments).			5	4.6	4.3	3.8	3.5	3.3	2.7	2.7	2.5	2.5	2.4	2.5	
	No contact within past 12 months			KPI not taken forward												
	Data completeness			KPI not taken forward												
	E4. Transitions – CAMHS - adults	CQUIN goals	Quarterly													
	E5 Developing a skilled workforce: Mental health act Mental capacity act Immediate life support	80%		Quarter end position												
			MHA (%)			71			82			87			85	
			MCA (%)			78			87			91			91	
			ILS (%)			75			72			77			81	
	E6. Competency framework for community nursing	Report	Annual													
	E7. Development of an integrated change network	Report	Annual													

Quality Domain	Key Performance Indicators		Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
					A	M	J	J	A	S	O	N	D	J	F	M	
CARING	**C1.** Friends & Family Test	Mental heath	85%	Monthly	85	82	86	89	79	85	86	86	86	85	86	86	85
		Community health services	98%	Monthly	97	99	98	95	99	99	97	98	100	97	97	99	98
		Trustwide	90%	Quarterly	84%			91			93			91			92
	CAMHS FFT		75%	Quarterly	61%			63%			66			63			63
	Forensic FFT		60%	Annual										51			51
	Learning disability services FFT		85%	Quarterly	91%			93%			95			97			95
	C2. Staff recommend the Trust as a place of care and treatment		80%	Quarterly	74%			75%						76%			
	C3. Volunteers - Peer project support project		Report	Annual													
	C4. Nursing strategy		Report	Annual													
	C5. Allied health professionals strategy		Report	Annual													

Quality Domain	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
RESPONSIVE	R1. Improve access to services: • Psychology for adults of working age • CAMHS – generic teams (average wait to choice contacts - days) • Specialist assessments and interventions within community LD services	RTT 18 weeks	Monthly	Quality Monitoring Desktop exercise September 2017												
		Trends	Barnsley	30	11	15	12	7	8	10	12	10	9	18	15	
			Calderdale	43	42	32	43	42	58	60	44	13	52	35	58	
			Kirklees	33	39	47	14	39	24	16	32	16	23	31	32	
			Wakefield	51	79	85	57	53	40	57	51	41	46	40	51	
		RTT 18 weeks	Quarterly	System established for collecting referral to treatment times. Please refer to table on page 68												
	R2. Complaint closed within 40 days (percentage of total complaints)	80%	Monthly	10	24	0	10	11	17	0	19	0	28	8	29	
	R3. Implementation of the plans for the freedom to speak up guardian.	NA	Quarterly													

Quality Domain	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position @ Q4/ Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
WELL LED	**W1**.Development of quality dashboard	Report	Annual													
	W2.Review of quality improvement monitoring, review and recognition system – 'quality scheme'	Report	Annual													
	W3.Development of a quality improvement toolkit	Report	Annual													
	W4.Increasing 'do and share' improvements.	Report	Annual													

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

Priority 1: SAFE

Why did we focus on this?

By safe, we mean that people are protected from abuse and avoidable harm. When mistakes occur, lessons will be learned.

'SAFE' quality initiatives in 2017/18

The following quality initiatives were prioritised for action in 2017/18 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-40.

S1. Improving physical health for patients with severe mental illness (SMI) by undertaking a cardio metabolic assessment and treatment for patients with psychoses

People with severe mental illness (SMI) are at increased risk of poor physical health. Their life expectancy can be reduced by an average 15-20 years due to preventable physical illness. Due to such things as heart disease and cancer caused mainly by smoking. There is also a lack of access to physical healthcare for people with mental health problems with less than a third of people with schizophrenia in hospital having received the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.

This year's cardio metabolic national audit of inpatient and community based mental health services were undertaken in Q3. For Early Intervention in Psychosis (EIP) services this was done via the Centre for Care Quality Improvement (CCQI) audit that was overseen by the Royal College of Psychiatry. In the case of inpatient and community based services this was done through the National Clinical Audit of Psychosis. The results from these audits are not expected until Q1 of 2018/19. However, the commissioners agreed to assess Q4 based on local results and reconcile as appropriate once the national results are available.

In relation to the local audit, the inpatient sample was taken from six cases across three localities of which there were no fails (see table below). The BDU level analysis indicated that all areas will surpass the 90% threshold for full payment from the CQUIN.

Inpatient

BDU	**Fail**	**Pass**	**Pass Rate**
Calderdale	0	1	100%
Kirklees	0	2	100%
Wakefield	0	3	100%
Barnsley	No audit		

The community sample was 168 cases across the three localities. Of these cases, 21 failed the audit (see table below). However, the BDU level analysis showed that all BDU's will surpass the 65% threshold target for full payment from the CQUIN.

Community

BDU	Fail	Pass	Pass Rate
Calderdale	0	17	100%
Kirklees	16	61	79%
Wakefield	5	45	90%
Barnsley	0	12	100%

The audit findings are not due until Q1 of 2018/19 and therefore clinical teams will be provided with feedback from these when we have those results. In the meantime to mitigate any risks , an online performance dashboard has been developed which provides teams with an evaluation of their performance based on the cardio metabolic assessments completed with their service users.

S2. Improving the physical health for patients with severe mental illness (SMI): Communication with general practitioners

With over 490,000 people in the total population with SMI, registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care.

Effective sharing and exchanging of information is essential between primary care professionals and secondary care mental health services about diagnosed physical and mental health conditions to ensure safe practice.

A working group consisting of GP's, Trust medics, pharmacy, governance leads, commissioners and operational managers have worked on a shared care protocol to meet the needs of our service users, services and the CQUIN. The protocol is currently at the draft stage and is being taken through the various organisations' governance frameworks.

The introduction of the shared pathway is intended to improve outcomes for service users by both increasing life expectancy and quality of life and should support primary and secondary care providers to keep records up to date whilst avoiding duplication and using resources more effectively. This integrated pathway is designed to give clarity on respective responsibilities and expectations at each stage of the SMI care pathway, support collaboration between services, and provide a framework on which to build high quality care for a particularly vulnerable group of service users.

During 2017/18 in Q3, we carried out a local audit of communications with GP's. This was to look at whether our service users have an up to date CPA (Care Programme Approach), care plan or discharge summary that was shared with their GP. This audit was undertaken in March 2018. The audit looked at a sample of 182 people across BDU's.
The results are as follows (see table below):

BDU	Fail	Pass	Pass rate
Calderdale	1	19	95%
Kirklees	4	41	91%
Wakefield	3	32	91%
Barnsley	6	76	93%

In order to reach our target we had to achieve a 90% pass rate. We have therefore managed to achieve our CQUIN target across all our services.

S3. Risk assessment indicator for integrated performance report

Work has commenced on establishing an indicator to determine compliance with the a standard set out in the Clinical Risk Management Policy which states that a risk assessment should be completed within 48hours of admission in an inpatient area, or within 48 hours of assessment in a community team.

Data is currently being analysed to ensure the indicator is reliable and valid. This indicator will be reported in our Integrated performance report in 2018/19

S4. Safer staffing

The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda and despite the lead on Safer Staffing having changed to NHS Improvement there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health/LD wards.

Whilst we have achieved our key performance measures for both trust wide fill rates and registered nurse fill rates, failing to maintain safer staffing within the clinical services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks. The Trust has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels.

The Trust consistently meets its safer staffing requirement overall with staffing fill rates continuing to exceed 100%, although the planned levels of registered nursing staff are not always met. The overfill rate is in response to clinical need (acuity) and results in existing staff doing additional hours, bank and the use of agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards but action throughout 2017 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff, significant reduction in agency use and initiatives to respond quickly to areas of need.

The Deputy District Directors and EMT receive monthly exception reports on fill rates (figures 1 and 2) within our inpatient areas with particular emphasis on areas where fill rate overall (Registered nurses and nursing support) is below 90%, and where Registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rates are not achieved, how it was managed and actions to prevent recurrence.

Analysis of fill rates September 2017 – January 2018

Figure 1a. **Registered Nurse Fill Rate Inpatient Areas per BDU Days**

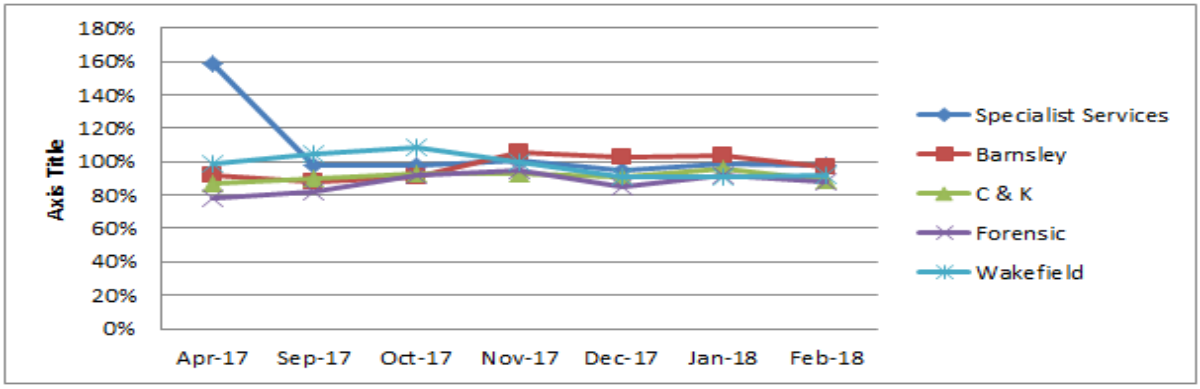
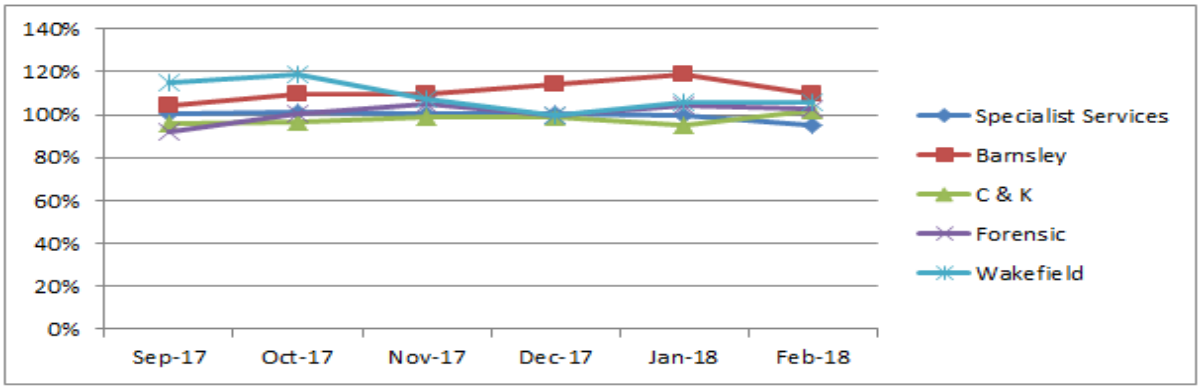


Figure 1b. **Registered Nurse Fill Rate Inpatient Areas per BDU Nights**



The plans we currently have in place will continue into 2018/19 and in addition we include:

- Involvement in the development of a National acuity and staffing resource, to ensure the trust is at the forefront of any developments
- Support establishment of cohorts of staff with annualised hours within BDUs
- Develop the Medical Bank capability
- Review staff bank policy
- Expanding the bank to support other areas including admin
- Interpret and act upon NHSI Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from May 2018
- Complete establishment review and share with operational services and Operational Management Group (OMG) as the basis for workforce planning going forward.
- Ensure recruitment of overseas registered staff to support the ongoing recruitment issues
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPT Retention Strategy

In August 2017 NHS Improvement (NHSI) asked all trusts to complete an audit of care hours per patient day which was completed in October 2017. This will be reported on monthly from May 2018. This and current plans will provide the platform from which to explore further workforce initiatives around the quality of care contact time, multi-professional approaches and use of non-registered staff.

S5. Incidents

For information on our incidents please refer to page 27, 'The number and percentage of such patient safety incidents that resulted in severe harm or death'.

S6. Pressure ulcers

Our Barnsley inpatient and community services are involved with the Sign Up to Safety national initiative. This initiative is to help NHS organisations and their staff to achieve their patient safety aspirations and care for their service users in the safest way possible. The reduction of pressure ulcers was previously a CQUIN within the Barnsley BDU although this is not the case at this point in time. However, we value this initiative as a good indicator of the care we are providing within this particular area.

Our target is to reduce the frequency of new pressure ulcers that are attributable to Trust care and avoidable, by 50% by 2018. At 31st December 2017 we had managed to achieve a 69.5% reduction and we will continue to implement the Sign Up to Safety plan which outlines the actions that are to be taken. These are periodically reviewed and remain ongoing.

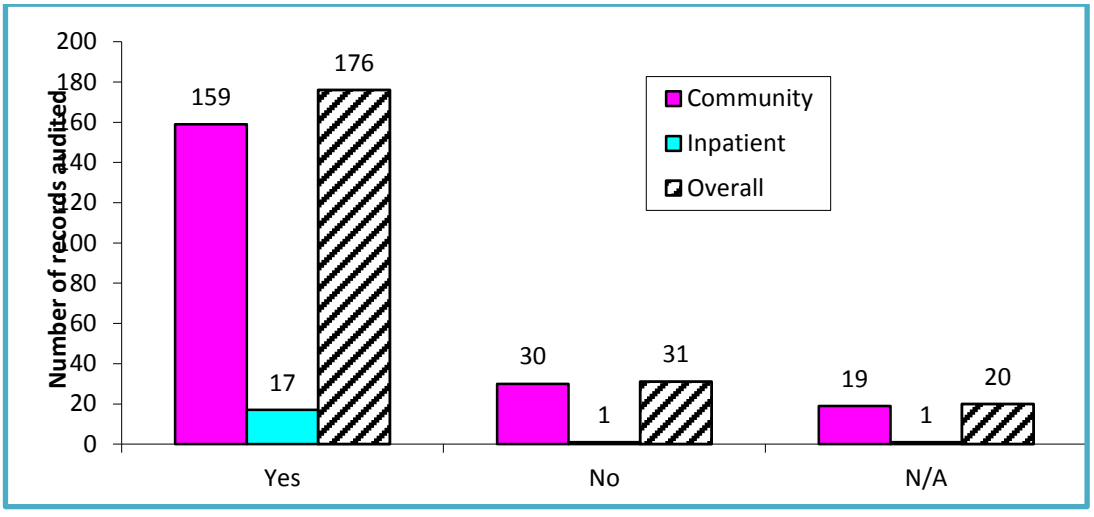
S7. Number of falls

The Trust has prioritised monitoring of falls as part of the integrated performance report, to note any trends and a number of audits have been identified to monitor the adherence to best practice. The number of falls reported over the year averages at 37.5 per month for the first 9 months. In February 2018 we saw a spike in the number of falls which increased the average to 60 per month. An investigation identified this spike was attributed to one service user (23 fall incidents).

During 2017 a re-audit was carried out in Barnsley BDU to make sure we were compliant and carrying out best practice in relation to NICE guidelines around falls, with the aim to demonstrate an increased compliance with the NICE guidance in comparison with the previous 2016 Falls Audit results.
The audit was undertaken by all adult services within BBDU during July and August 2017. In total 227 records were audited, 207 in the community and 20 within inpatient areas.

Overall it was found that 45 out of the 50 services audited were demonstrating best practice and adherence to the NICE guidelines. The table below shows the breakdown in relation to whether falls screening tools were being completed within community and inpatient settings.

Falls screening tool completed (n=227)



As shown above, the results indicate that 176 out of 207 of the records audited (85%) showed that a falls screening tool was completed. In 20 cases the records stated this was not applicable for a variety of reasons e.g. service user was fully mobile independently, tool had already been completed by the district nurse.

The audit also looked at other aspects of the service user's care in relation to falls. This covered areas such as:

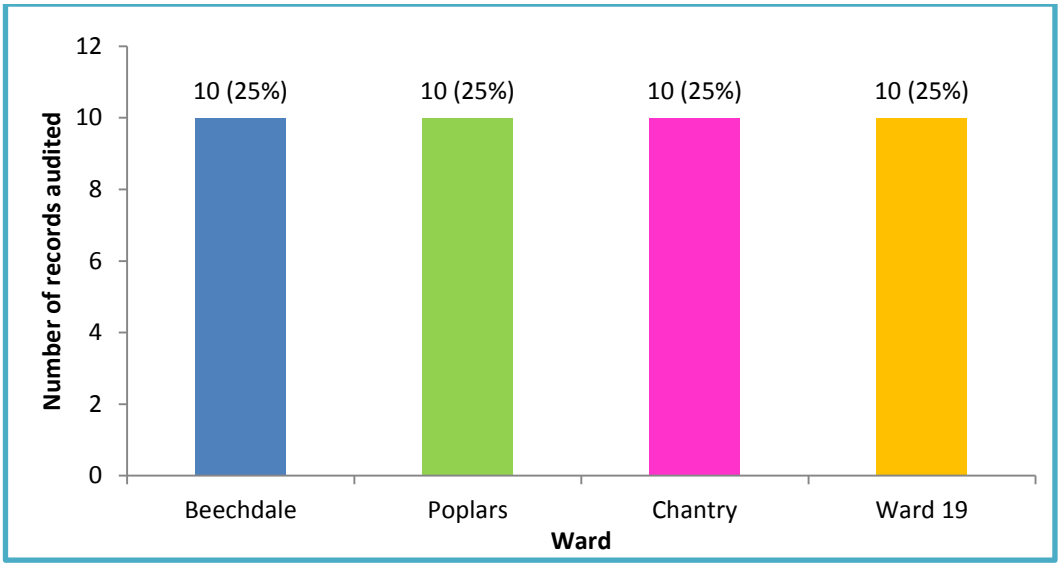
- The person's reported history of falls
- Noted abnormalities of gait or balance
- Service user was offered a multifactorial risk of assessment where identified at risk of falls (possible referral to other services)
- Was the service user offered information on reducing risk of falls and appropriate interventions
- Service user involvement in decision making
- Carer involvement in decision making

The audit identified that 90% of services were demonstrating best practice and adhering to NICE guidelines in relation to falls. It also found that compliance with NICE guidance across the BBDU had shown a 22% improvement from the previous audit (68%) that had been completed in 2016. In those services where the Falls Screening Tool is not routinely completed e.g. Podiatry Services, they have included the NICE Falls Screening trigger questions into their core assessments.

A second audit was undertaken on inpatient wards across Calderdale, Kirklees and Wakefield. The main focus in this area of work was to audit how the falls risk assessment tool (FRAT 18) was being used within older peoples' inpatient services both in terms of its frequency of use and completeness. The FRAT audit tool has recently been rolled out within our older peoples' inpatient services and is recommended for working age adult service users who are over 50 years old. The FRAT 18 tool is NICE approved and should be used within 24 hours of hospital admission. The aim of the audit was to ascertain whether teams were compliant with the NICE guidance and to highlight any areas for improvement and development.

The audit was undertaken on four older peoples' inpatient services during March 2018. In total 40 records were audited, 10 from each of the four inpatient services. The following is a summary of the records audited from each older peoples' wards

Wards



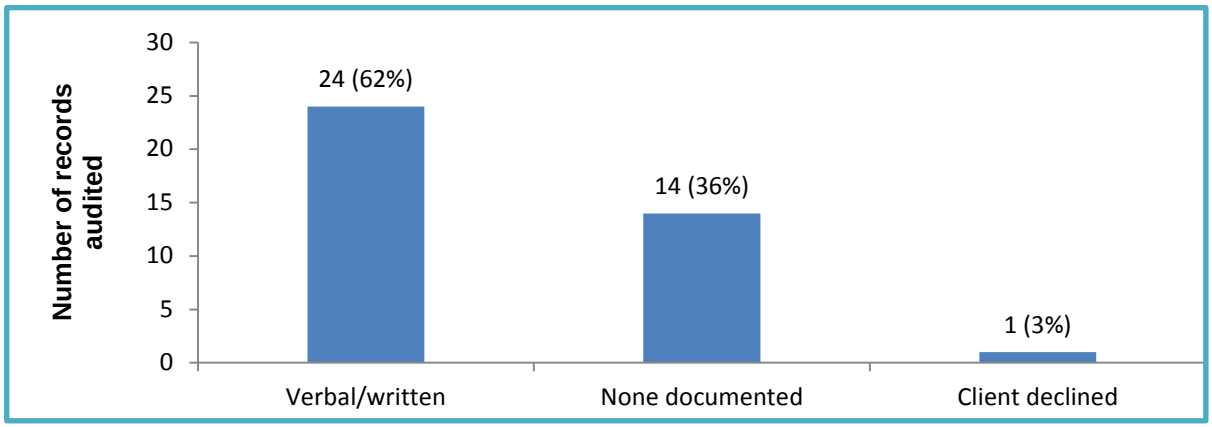
When we looked at the 40 care records we found that in all 40 cases (100%), records showed that a falls screening tool had been completed. Where service users had been identified as being at risk of falls, in

every cases referrals had been made to physiotherapy. All the records audited also contained identification of the service user's falls history within the assessment.

In cases where the FRAT 18 assessment highlighted the need to refer the service user to other services, in 95% of cases these referrals had been made.

The audit also looked at whether service users were offered either written or verbal information on reducing falls and appropriate interventions. The table below shows the breakdown of information offered

Information offered:



The overall results are pleasing and show the FRAT 18 is well embedded into OPS in-patient areas, more focus can be put on the subsequent re-audit to look at when the FRAT 18 was done in the admissions process and potential barriers to its prompt completion.

S8. Restraint & prone restraint

We monitor these indicators in our integrated performance report as they are important to patient safety and have been identified in our patient safety strategy and sign up to safety action plan as a key performance indicators.

National guidance from the Department of Health (DH), Positive and Proactive Care, places an increasing focus on the use of preventive approaches and de-escalation for managing behaviour that services may find challenging and reducing the need for restraint. When we do need to use restraint it should be for the shortest time possible and use the least restrictive means to meet the immediate need based on the fundamental principles in Positive and Proactive Care. This is supported by the 2015 Mental Health Act Code of Practice which states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position". NICE guideline NG10: Violence and aggression also recommends avoiding prone restraint, and only using it for the shortest possible time if needed. Prone restraint, placing a person face down during restraint, increases the risk of physical harm and hence the importance of keeping this practice to a minimum.

Type of restraint	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Number of restraint incidents	345	424	442	599
S8 Number of prone restraint incidents that lasted less than 3 mins (percentage of all prone restraints)	75%	80%	77%	76%

We have seen an increase each quarter in the number of restraint incidents across our services. Further analysis of this data is being undertaken but it is anticipated this may be linked to an increase in acuity. Each episode of restraint is reviewed by the clinical team and specialist advisors to ensure a cogent reason for restraint. The incidents are spread across BDUs and a small number of individuals have multiple incidents reported. The Restrictive Practices trust action group review all restraint information and keep an overview of required actions. This group provides exception reports into the Clinical Governance & Clinical Safety Committee.

For each episode of prone restraint clinical staff must clearly identify why alternatives could not be used. The restrictive practice specialist advisors and safeguarding leads review this information and where it is felt prone restraint was used inappropriately a reflective debrief is instigated.

A point to note is that as our prone restraint figures are small, the percentage is likely to be affected the greatly by 1 or 2 extra as, for example, August recorded only 4 restraints above 3 minutes, giving a total 86.2% below 3 minutes, September had one more (5) but because there were actually 9 less prone restraints in total – the figure less than 3 minutes drops by 10% to 76%.

S9. Suicide strategy implementation

Suicide prevention is a national, regional and local priority, reflecting the government's suicide prevention strategy 2012, and involving a wide variety of agencies including health care providers, local authorities, emergency services and third sector bodies. Our aim is to draw on a variety of sources to identify best practice and to tailor this to meet the needs of the population served by the Trust. There are 2 main objectives; a reduction in the suicide rate in the general population in England and better support for those bereaved or affected by suicide. There are 6 key areas upon which efforts are focussed.

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

The Trust's suicide prevention strategy incorporates elements of all of these groups.

What progress has been made?
The suicide prevention strategy implementation group meets quarterly. Work is already ongoing within the Trust to meet the strategy commitments was identified and an action plan addressing each of the commitments within the strategy has been developed. This has been further refined to prioritise particular actions for years 1-3, running from December to November, with identified outcomes for each of the domains in the strategy.

Work has included:
- Promoting the strategy and the message that suicide is preventable
- Information about the strategy has improved including a leaflet for staff and talks around the Trust
- Information developed on support for those bereaved by suicide. Lead for staff support.
- Datix has been developed to improve the coding of deaths and collection of additional data for analysis of apparent suicides reported in the Trust
- Work across West Yorkshire Suicide prevention group to develop a West Yorkshire-wide suicide prevention strategy (the Trust has had the lead role).
- Sharing information about suicide risks identified when incidents and near misses have occurred, such as ligature points and methods
- A research project involving artificial intelligence has produce a draft clinical decision support tool in relation to assessing suicide risk

- Development of discharge planning protocols to improve quality of transfer of information on discharge, a key risk period.

Risk training now mandatory and high level of take up (79.8%)

- Ongoing review of risk assessment tools and their utility in the Trust. CAMHS now introduced standardised use of Sainsbury tool.
- Safety huddles now taking place regularly
- BDU learning events are increasingly including clinical discussions of real cases, encouraging reflection and a culture where reviewing care openly is the norm.
- Developments in dual diagnosis care planning
- Suicide prevention training being delivered with Wakefield Recovery College
- The Trust has a lead role in the development of a West Yorkshire suicide prevention strategy as part of the Sustainability and Transformation Plan (STP), the Deputy Director Nursing and Quality chairing the project group, with a project lead being secondment from the Trust.

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Suicide prevention remains a quality priority for the trust in 2018/19 when we will focus on:

- Continue to engage more staff in awareness of suicide prevention efforts and what they can do.
- Target 'excellence in treatment of depression' as particular focus for clinical interventions.
- Review and if necessary propose development for personality disorder services and management for deliberate self-harm
- Align Trust strategy priorities with the WY strategy
- Ensure that pilots, where successful in one BDU are then rolled out across the Trust
- Ensure that efforts being made across the Trust in other initiatives (e.g. patient safety strategy and other policy developments/implementation) are captured where they are relevant to suicide prevention, and so that duplication of effort is avoided.
- Project to improve mental health in those with chronic physical health problems
- Review of observation policy in line with National Confidential Inquiry proposals.
- Develop any outstanding or in-progress action plans commenced in year 1 over into second year
- Bring into action the role of BDU suicide prevention leads
- Engagement of service users/carers in key activities
- Work up a case for making suicide awareness/intervention mandatory for key staff

S10. Mortality reviews

Events in Mid-Staffordshire and findings from the CQC report 'Learning, candour and accountability' identified that learning from deaths was not being given enough priority in some organisations and opportunities for improvements were being missed. The findings found that better engagement was needed with families and carers to recognise their roles. They also identified that poor leadership and system-wide failures were contributory factors for poor quality provision. It was recognised that care providers needed to do more in their investigation to:

- Understand the causes and contributory factors within care

- Learn in order to prevent occurrence

- Share and act upon findings

The National Quality Board (NQB) set out new reporting requirements in 2017 in relation to learning from a review of the care to service users who die, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts were asked to share and act upon learn and to treat mortality governance as a key priority for Trust boards and to understand the issues affecting mortality; providing necessary challenge when needed.

As part of the 2017/18 audit plan, SWYPFT requested a review of mortality by our internal auditors (360 Assurance). This has been completed and the final report was produced in early April 2018.

The aim of the review was to provide independent assurance about the robustness of our governance processes to oversee mortality and the quality of the mortality data being provided. 360 Assurance assessed the systems and processes in place to ensure we are compliant with the National Quality Board's 'National Guidance on Learning from Deaths' framework for NHS Trusts.

The review outcome was that 360 Assurance was able to provide significant assurance around our mortality systems and processes. The risk management activities and controls were suitably designed and were operating with sufficient effectiveness to provide assurance that the control environment was effectively managed. The review also identified that a significant amount of work had taken place since the NQB set out their requirements in March 2017. Whilst recognising some requirements still needed to be fulfilled. These improvements have led to:

- Controls and quality improvements at operational and strategic levels providing assurance on mortality governance in relation to learning from deaths.
- Robust arrangements for assurance on relevant mortality data collection, including reporting and monitoring via the Trust's Datix incident management systems and governance structures.
- A Trust wide focus on establishing robust mortality arrangements as a key priority, ensuring internal assurance and monitoring.

For information on Learning from Deaths incidents please refer to page 28.

What next?

The quality initiatives in the SAFE domain which we will undertake in 2018/19 to help us achieve our aim 'to improve and be outstanding' are: to continue the work we have started on improving the physical health needs of people who have severe mental health problems; improving our safer staffing fill rates; continue to improve our patient safety strategies to reduce harm, continue with the implementation of our suicide prevention strategy and safeguarding, and a focus on our environments.

Priority 2: EFFECTIVE

Why did we focus on this?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

EFFECTIVE' quality initiatives in 2017/18

The following quality initiatives were prioritised for action in 2017/18 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36 – 40.

E1. Improve the quality of care planning

The quality of care planning is aligned with our values and is underpinned by best practice e.g. NICE, CPA policy and the NHS outcomes framework.

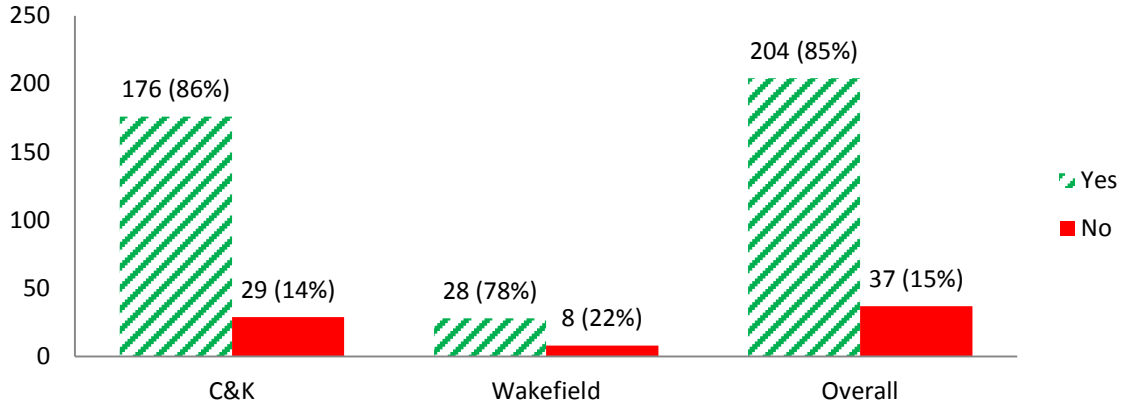
Our aim is to make sure our care plans identify personal risks, are developed in a person centred way, and have a crisis plan which identifies what support people can access, and how to access this when they need to.

An audit of the clinical records was carried out in Calderdale, Kirklees and Wakefield to assess our compliance with these standards. Accurate records are essential to support high quality treatment and care. Inaccurate records can lead to delays in service users receiving treatment, inappropriate care and duplicate records, which all present risk to the service users.

The results for Calderdale & Kirklees and Wakefield are summarised below.

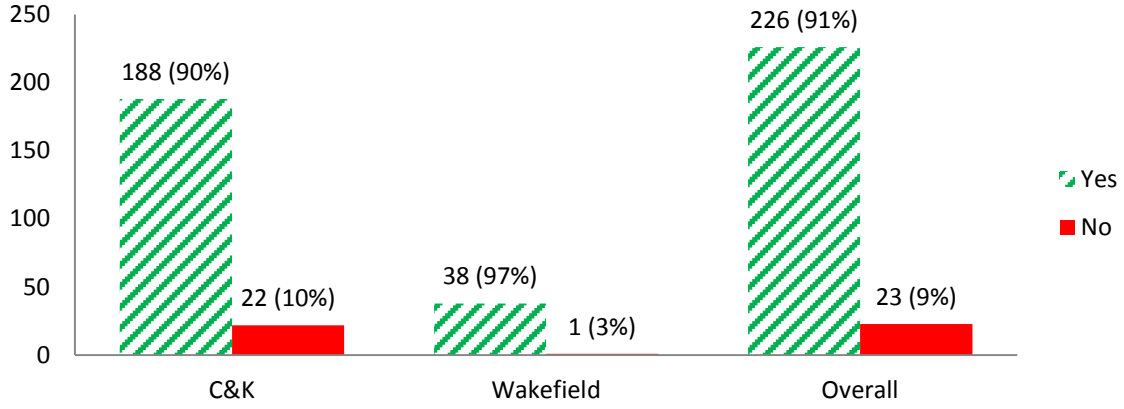
The results for each question and the overall compliance for the standard are shown in the tables below.

1. Is there documented evidence that identified risks are reflected in the care plan? (n=241)



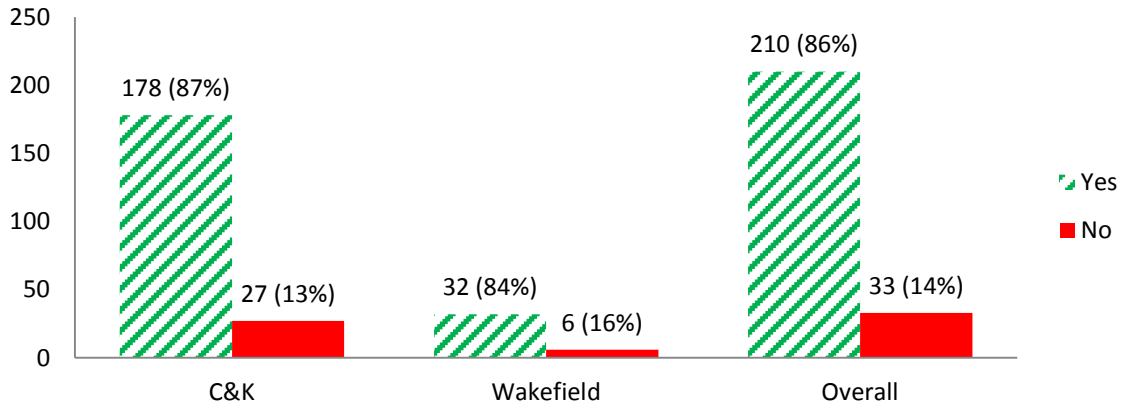
Overall, 85% of case notes audited had documented evidence that identified risks were reflected in the care plan. Compliance was partially met.

2. Is there documented evidence that the care plan was developed in a person-centred way? (n=249)



Overall, 91% of case notes audited had documented evidence that the care plan was developed in a person-centred way. Compliance was fully met.

3. Where appropriate, is there a crisis and contingency plan with signs of relapse, individualised responses to relapse and where relevant specific contacts and information? (n=243)



Overall, 86% of case notes audited showed that where appropriate, there was a crisis and contingency plan with signs of relapse, individualised responses to relapse and where relevant specific contacts and information. Compliance was partially met.

The results indicate a high level of compliance with the standards and we have achieved our goal.

E2. Clinical supervision

When CQC visited the Trust in March 2016, they told us that we must make sure staff receive appropriate supervision. This entails clinicians having a minimum number of hours supervision each year. They also commented that the Trust had no effective systems in place to centrally record when staff were having supervision.

Since our CQC visit in March 2016 we have made a number of improvements with our staff supervision systems. These are as follows:

- The framework for accessing and delivery of supervision has been changed and updated to reflect the changes in how the service is managed. This takes into account such things as the implementation of 12 hour shifts within inpatient areas
- The updated framework has encouraged a more flexible approach to supervision. A supervision 'passport' has been introduced whereby staff can access supervision when available and from a range of people rather than just one person
- The 'passport' system is used using the following principles, i.e. this type of supervision is correctly structured, recorded and follows the established model for delivery as referenced in the Trust's policy on Clinical Supervision
- Supervisors who are providing this form of supervision are trained and so this style of supervision represents only a small percentage of the stipulated 12 hours of supervision per year. At least four hours of supervision needs to be provided by the staff member's regular supervisor with whom the individual holds a contract
- A number of additional staff have now completed training which has led to an increased number of clinical supervisors who can provide clinical supervision
- There is now a Trust-wide list of supervisors that is kept up to date and reviewed regularly for staff to view and access
- There is a centralised Trust supervision database for recording and reporting supervision. This helps teams to better monitor their supervision rates and uptakes and to identify where supervision is not taking place

- The database will also be helpful in planning of audit supervision so we can measure ourselves against our own expected standards
- A number of teams have set up group supervision processes that are generally led by a psychologist. This is useful when reflecting on practice and in identifying where good practices have been followed and can be shared with others.

The progress made as at March 2018 is reflected in the clinical supervision data in the table below:

BDU	Supervision % March 2017	Supervision % March 2018
Barnsley District	42.7%	78.84%
Calderdale/Kirklees District	29.6%	92.74%
Forensic Services	78.8%	93.21%
Specialist Services	31.5%	86.27%
Wakefield District	24.0%	91.98%
Grand Total	**39.5%**	**86.91%**

We pledged that during 2017/18 we would continue with our focus on supervision and we have done so. We continued to implement the actions and embed these in practice. We set ourselves a goal of achieving 80% of registered professionals receiving clinical supervision and we achieved an overall Trust figure of 86.91% in March 2018.

We will continue to focus on the uptake of clinical supervision by professional staff going forward.

E3. Timely review of care and treatment: appointments that have no outcome

The accuracy of clinical records is of upmost importance in delivering safe, effective care. To improve the quality of our clinical record keeping in the Trust we undertook a focused piece of work to improve standards of data quality across the Trust's clinical services.

Data quality usually refers to the quality of aggregated outputs from many clinical records and the impact this has on analysing the data. For example, a detailed narrative within a clinical record explaining all about the client and the treatment they have received may be a good clinical record but unless it is input into structured fields that can be aggregated with other records and analysed, the data quality is poor.

Data quality is also impacted by the timeliness of input into the individual clinical record. If the information is not recorded until weeks after the contact with a client has occurred it is likely that it will not be included in aggregated data that flows to commissioners and other external bodies.

For these reasons the trust has developed a data quality dashboard, which can be filtered by BDU, team and individual health care professional. One of items on the dashboard, which we have chosen to monitor in the quality account is appointments that do not have any outcome, i.e. Un-outcomed contacts (these won't get counted in activity reporting, flow in national datasets or stop wait time clocks). For the past twelve months each BDU has an action plan to reduce the number of un-outcomed appointments and the figures have reduced from 5% of all appointments with no outcome in April 17, to 2.5% in March 18. We will maintain this focus to ensure we can demonstrate the effectiveness of our services.

E4. Transitions out of children and young people's mental health services (CAMHS)

Nationally young people and carers who use CAMHS feel that the transition between children and adult services is not always supportive and can be daunting and somewhat traumatic for young people as they do not know what kind of service they will receive. Carers can feel unsupported and sometimes struggle with the change in focus. There have been gaps identified in service provision and at times there are not like for like services available post transition. Thresholds for accessing adult services also differ in some areas and historically there have been instances where children have been lost within systems, thus placing them at greater risk.

For these reasons, in 2017 /18, NHS England identified a national CQUIN to address the transitions out of CAMHS. The CQUIN aims to incentivise improvements to the experience and outcomes for young people at the time of and post transition. Achievement of this CQUIN is measured by the results of the three components: a case note audit in order to assess the extent of Joint-Agency Transition Planning; a survey of young people's transition readiness ahead of the point of transition (Pre-Transition / Discharge Readiness); and a survey of whether young people are meeting their transition goals after transition (Post-Transition Goals Achievement Survey).

Component 1

A case note audit was undertaken during March 2018 for young people turning 18 years of age and transitioning out of CAMHS during Q4. The audit covered the following CQUIN requirements:

- The young person had a meeting to prepare for transition
- A transition action plan had been developed including identifying goals with the young person
- A discussion with GP had occurred if the young person was transitioning to back to GP
- An adult team key worker (future care coordinator) had been identified if transitioning to adult mental health services

The results for the case note audit are as follows:

Met all audit requirements	19
Did not meet all requirements	4
Total	23 (82.61%)

Component 2
A pre-transition survey questionnaire was completed by the young person.

The results are as follows:

Response	Did you feel that decisions about your goals were made together by you and the person you saw during those discussions?	Were the reasons for this change explained to you at the time?
Yes (completely/ some extent)	11	12
No	2	1
Total	(84%)13	(92%)13

Component 3
A post-transition survey questionnaire will be conducted in Q1 2018/19, allowing the young person time to achieve their transition goals.

During 2017/18 the trust has taken a number of activities to ensure we have robust processes in place to ensure a young person has a safe, effective transition when they move on from our CAMHS teams, these include:

- A trust-wide transitions steering group has been established
- The trust-wide transition policy was reviewed and interpreted into local actions
- Local area transition groups have been established
- Transition Links have been identified across the teams
- Performance & Information Dept. produce a monthly report which identifies all young people who are aged 17½ years of age in the service to inform mangers/clinicians to support the initiation of the transition process
- Review of transition plans are reviewed with practitioners in management supervision
- A collaborative, dynamic care plan is produced with the person and whichever service is agreed to best provide ongoing support/care as appropriate.

Significant work has been undertaken to ensure we have effective channels of communication between adult and CAMHS services. We have seen an increase in joint working between services to support good transition practices, which are reflected in the results of the pre transition questionnaires.

E5. Developing a skilled workforce

When CQC visited the trust in March 2016 they told us we must make the Mental Health Act and Mental Capacity Act training mandatory for specified members of staff, and improve the attendance rates of our Immediate Life Support training (ILS).

Between March 2016 and January 2017 a significant amount of work was undertaken to ensure we achieved the must do actions that the CQC required. We described this work extensively in our Quality account report 2016/17.

Throughout 2017/18 we have maintained our focus on attendance at these mandated training courses and have achieved the key performance targets we set ourselves.

E6. Development of an integrated change network

A proposal to establish the Trust Integrated Change Network was approved by the Trust Executive Management Team (EMT) June 2017. The newly adopted Integrated Change Framework for the Trust is operationalised through a core, integrated change team and a wider network of people from across the Trust.

The development of the Trust Integrated Change Network is based on a series of underlying principles which have been drawn from the evidence base on:

- Networks and in particular the work of Becky Malby et al at the Centre for Innovation in Health Management (CIHM)
- Social movement – considering the work of Helen Bevan et al
- Communities of Practice – considering the work of Myron Rogers

We have taken elements from the evidence base on networks, social movements and communities of practice and developed principals for how the Trust Integrated Change Network will function and these are explained below.

The network will bring people together to:

- Provide a collaborative environment for learning and development on effective approaches to change so we become more skilled and have a shared understanding and language
- Inspire, engage and align our collective effort on improvement of care and delivery so we enable all of us to be more effective in achieving our strategy
- Create a critical mass of people who can more effectively act as change/improvement/innovation facilitators in their own environment
- Model co-production as a mechanism for improvement and change of services and helps us improve and be outstanding

The network will specifically bring together the following functions: Innovation; co-production & engagement; marketing and communication; project and programme management; change management; organisational development and leadership development; business development; involvement and engagement (including volunteering); improvement, measurement and finances; knowledge management use of resources e.g. estate

The membership will not be static and will be drawn from several sources for example, staff within the organisation (including the charitable arm) who have specific roles which support the implementation of change. These people will be required to input their specialist knowledge and experience, Volunteers: the network will include people who are passionate about change and improvement and who wish to be part of the new network. This would specifically include people with lived experience, and targeted additional people to be creative and representative we would reserve the option to recruit others, if required, to ensure that there is diversity of views and people within the network

Underpinning principals for the way the network will work

- As a managed network of people who meet face to face and also receive information through use of technology (e.g. e-mail, i-hub)
- Equal peer relationships based on generosity and reciprocity (of time, skills, information, resources)
- Requests and offers of help so that members are able to do their job more effectively
- Clear and transparent rules of membership
- Trying things out iteratively and sharing learning from mistakes and successes

The work on the development of the network has commenced with the aim of a launch in 2018/19.

What next?

The quality initiatives in the EFFECTIVE domain which we will undertake in 2018/19 to help us achieve our aim ‘to improve and be outstanding’ are: policy and procedure system review, Introduction of outcome measures, implementation of new NICE procedure, developments to support our workforce, implementation of the new electronic record system in mental health, new pathway development for personality disorder and clinical record keeping.

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Priority 3: CARING

Why did we focus on this?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
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.

'CARING' quality initiatives in 2017/18

The following quality initiatives were prioritised for action in 2017/18 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-40.

C1. Friends and Family Test

The Friends and Family Test (FFT) is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This feedback should be used to improve services for service users.

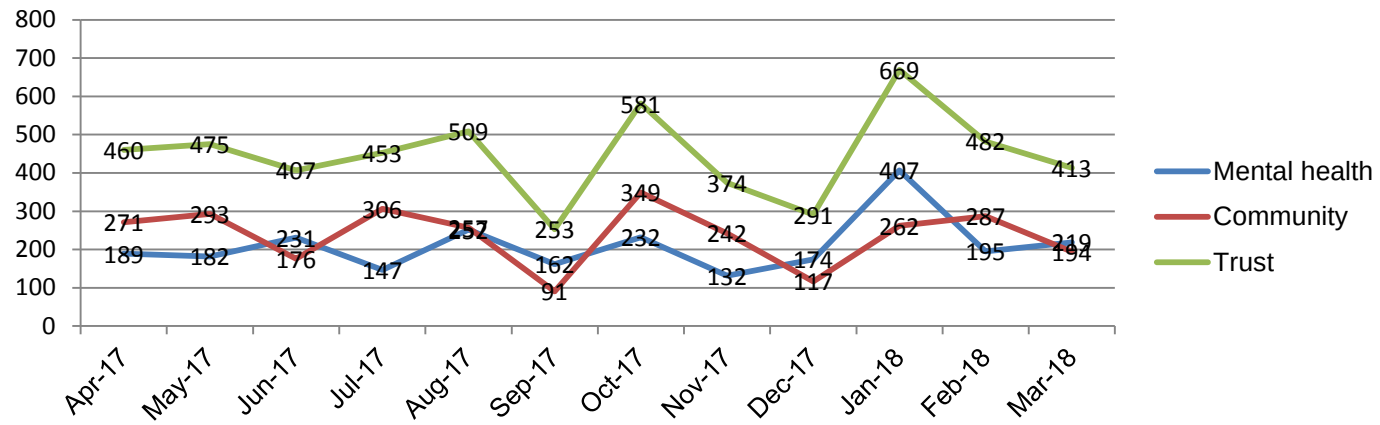
The FFT question asks if people would recommend the services they have used and offers a range of responses from 'Extremely likely' to 'Extremely unlikely', including a 'Don't know' option. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor service user experience.

The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results are also a useful source of information which can help to inform choice for service users and the public. The results are available on the NHS England website and the NHS Choices website.

The FFT was implemented in the Trust in 2015. The Trust is on a progressive journey of continually refining and improving systems and processes for the collection of service user feedback.

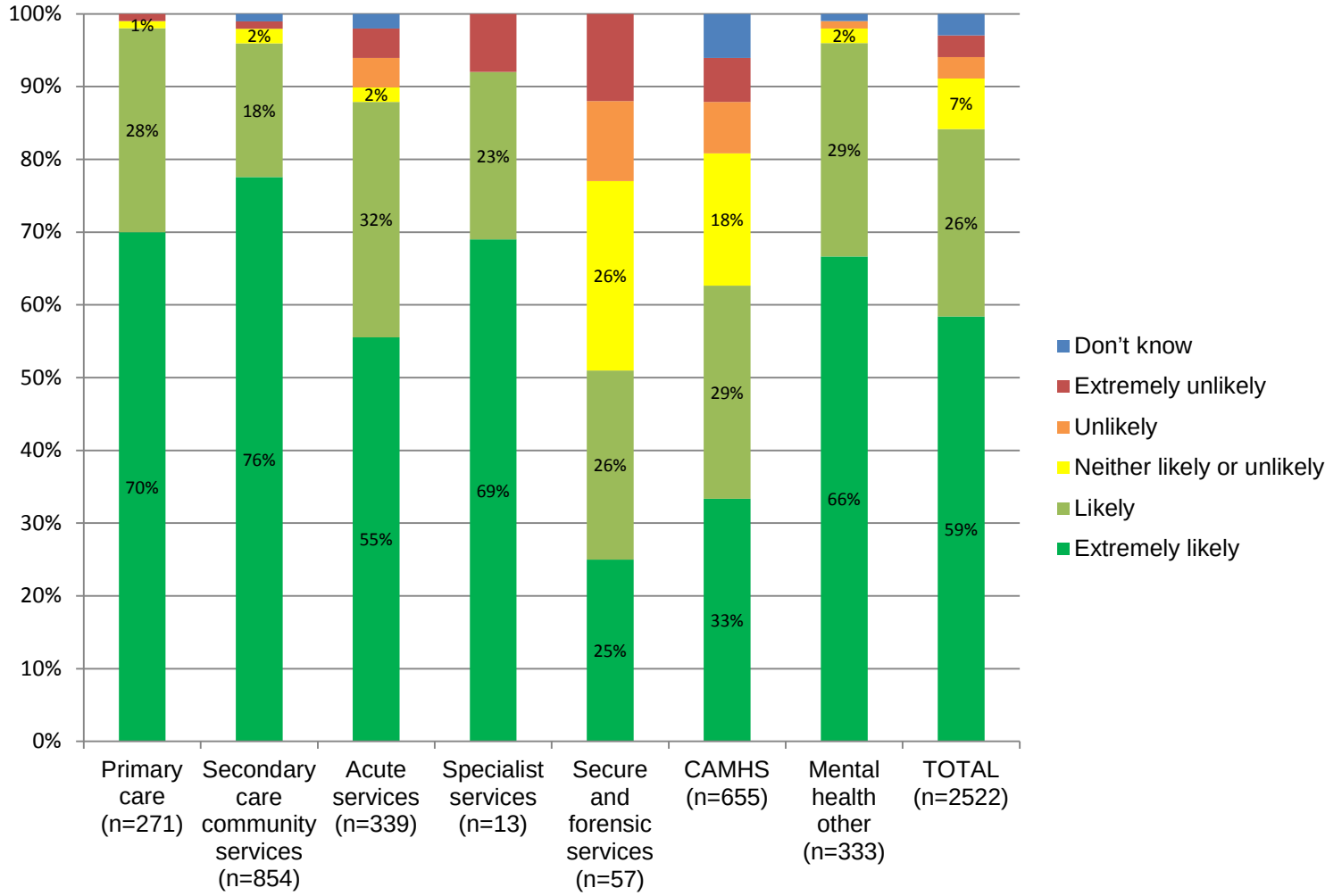
In 2017/18, the Trust received 5367 individual pieces of feedback, an average of 447 responses per month.

Friends and Family Test responses in 2017/18



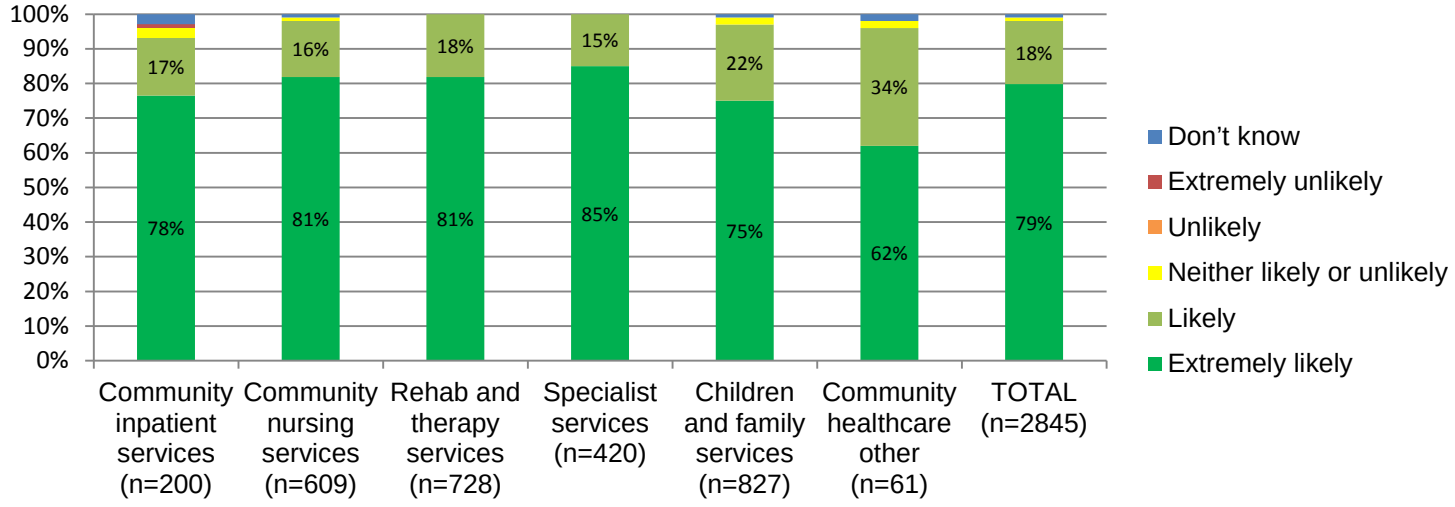
The results breakdown as follows:

Mental health Friends and Family Test



85% would recommend mental health services, 6% would not.

Community services Friends and Family Test



98% would recommend community services.

The Quality Improvement and Assurance Team (QIAT) works closely with members of the leadership trios to ensure that teams are collecting, reviewing and acting upon feedback. Low responding teams are identified and offered advice and support. Areas of concern (areas consistently scoring low) are highlighted and offered support to help improve their service.

It has to be noted that comparing teams' results is difficult due to the differing collection methodologies. It has been acknowledged that responses collected in clinical waiting areas are generally centred on that particular waiting environment i.e. availability of refreshments, furniture etc. The majority of comments received post-discharge are more general in their content.

The FFT has now been established for a number of years. The original national focus on it being a 'comparable metric' has diminished, and there is more of a focus upon the FFT being a feedback tool that allows providers to make real changes based on the free text comments.

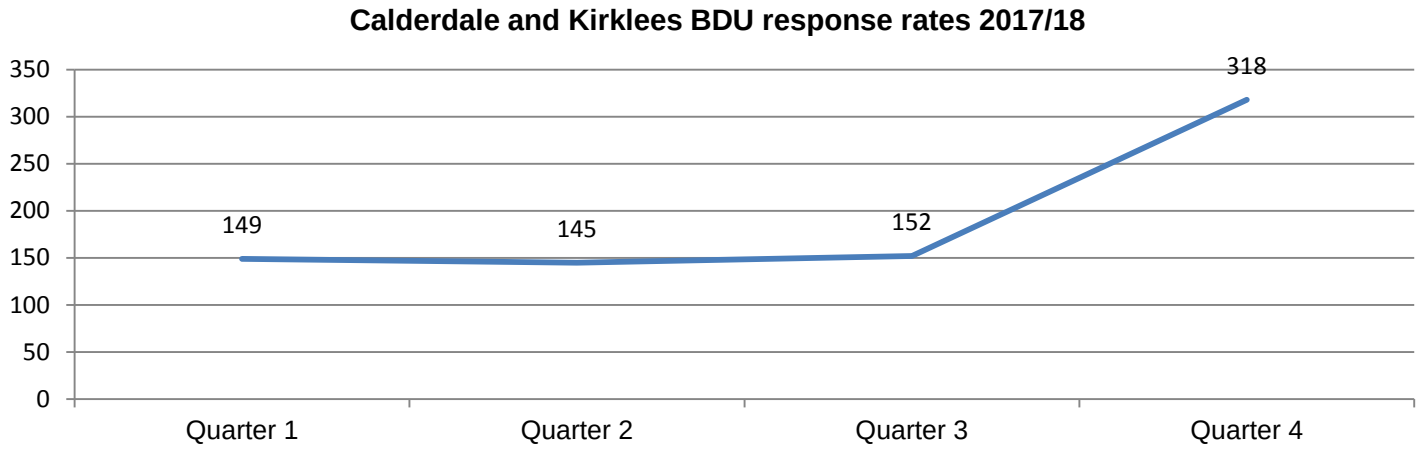
Percentage of people extremely likely / likely to recommend services

	Community health	Mental health	Overall Trust Score
2014/15	98%	90%	94%
2015/16	98%	81%	90%
2016/17	98%	73%	87%
2017/18	98%	85%	92%

	CAMHS	Forensic BDU
2014/15	69%	55%
2015/16	67%	45%
2016/17	59%	47%
2017/18	63%	51%

Since collection began in 2014/15, community health services have maintained a consistent recommendation percentage of 98%. However, in mental health services the recommendation percentage has fluctuated. This is mainly due to the lower scores received in CAMHS and Forensic services. Both have seen an increased recommendation percentage in 2017/18 giving Mental Health services an overall increase of 12% from the previous year.

Despite a number of services being decommissioned in 2017/18 the high number of responses received by the Trust has been maintained. Learning disability services introduced the use of technology in their services, helping them to up responses from 45 in 2016/17 to 333 in 2017/18. Calderdale and Kirklees BDU introduced a minimum number of responses per team that should be collected on a monthly basis. The graph below illustrates the increase in response rate when the minimum response requirement was introduced in Quarter 4:



Developments for 2018/19

Volunteering – Throughout 2017/18 the Trust has been piloting the use of volunteers in collecting service user experience. A role description was created and volunteers were recruited from across the South West Yorkshire area. Volunteers performed a number of roles including:

- Meeting and greeting service users and carers at community hubs
- Aided service users and carers with amenities
- Collected service user experience on iPads in both community and inpatient settings

The pilot has been successful and the volunteering service will be up-scaled throughout 2018/19

Governance arrangements – The governance arrangements around service user experience are being reviewed with BDU's to ensure all areas are collecting, reviewing and acting upon feedback

Re-launch of the brand – Service user experience will be re-launched across the organisation, starting with 'Experience of Care Week' in April 2018. Service user experience is included in the Trustwide campaign #allofusimprove.

C2. Staff Friends and Family Test (Staff FFT) - staff recommend the Trust as a place of care and treatment

The FFT is a simple feedback tool which allows patients and staff to give their feedback on NHS services. The two questions included in the survey for the Staff FFT ask for feedback on colleagues' recent experience of working at the Trust in the form of two questions, both of which include free text comment boxes:

1. How likely are you to recommend the Trust to friends and family if they needed care or treatment?

2. How likely are you to recommend the Trust to friends and family as a place to work?

Staff FFT data is collected in quarters 1, 2 and 4 each year. We monitor staff FFT question 1 as part of the quality account process as we believe this is a good indicator of the quality of care we are able to provide.

During 2017/18 the result has remained constant with 74%-75% of staff recommending the Trust to friends and family if they needed care or treatment, which is 5% below the goal we set. In the previous year we have achieved this goal, achieving 80%.

Feedback against this question

Overall the headcount of staff completing in each BDU is small. A number of comments were received from staff, a significant majority of which are positive. Key themes in the positive statements are:

- hard working, caring, committed and dedicated staff
- commitment to the Trust values
- commitment to employee well-being and support for staff
- supportive management

Negative comments contained a number of key themes.

In the Barnsley BDU a number staff shared concerns regarding the decommissioning of services and changes at Mount Vernon Hospital. There were also concerns regarding waiting times and pressure on staff. Some staff felt that management support could be improved including the need for increased recognition for staff.

Each BDU receives a bi annual staff wellbeing report and has an action plan to ensure we take effective action to address issues, with the aim of supporting our staff to deliver the best possible care. The Well Being in Partnership group oversees the action plans and has a strategic action plan to oversee the improvement work needed.

C3. Peer support project Develop volunteering strategy to support service user experience

The health and social care system is under pressure to improve the quality and efficiency of services. To meet the challenges and support our programme of transformation we need to think differently about how we work and how we enhance our services and communities. Evidence and research, from NCVO (National Council for Voluntary Organisations) NAVSM (National Association of Voluntary Services Managers NHS), and Volunteering England validates that volunteering adds value in a variety of ways:
To our service users – receiving support from volunteers is associated with high self-esteem, improved wellbeing, and lower levels of social exclusion, isolation and loneliness among service users.
To our service user volunteers – providing social and life skills enables them to live well in their communities and provides experience for employment. It builds confidence and the ability to converse and interact on all levels; it builds a sense achievement and recognition enhancing mental wellbeing.
To volunteers - volunteering can have a constructive impact in terms of improved self-esteem, wellbeing and social engagement. The benefits for older volunteers have been particularly well researched; they appear to experience less depression, better cognitive functioning, improved mental wellbeing and quality of life compared to those who do not volunteer. Young people learn better social interaction skills, integration into their communities, improved self-esteem and sense of purpose. It provides a diverse set of life and social skills, improving confidence within a social setting.
To connect us further with our communities - volunteering brings wider benefits to communities, enhancing social cohesion; reducing antisocial behaviour among young people, volunteering encourages people to get involved in other activities in their communities and provides a sense of belonging.

In addition to our council of governors, who all volunteer, we currently have over 201 volunteers and 40 awaiting placements, equating to 660 hours per week, 2,640 hours per month, 31,680 hours per year. Requests to provide opportunities for more people, who would like to give their time and expertise have been received and there are many opportunities for service users to get involved in meetings and discussion groups. Examples of volunteer roles are:

- Health champions in Wellbeing services.
- Involvement in service improvement groups and staff recruitment processes.

- Partnership working with Mind, Richmond Fellowship, First Choice who volunteer in our mental health service and catering departments.
- University students collect and process data on Family and Friends and Equality data.
- External volunteers and internal staff volunteers support the Museum.
- Befriender volunteers provide social interaction in our services and communities.
- People volunteer to support special interest groups such as charitable funds, stop smoking etc.
- Volunteers work within Recovery Colleges at Barnsley/Wakefield/Calderdale and Kirklees.
- An APTS volunteer just gained employment with the team.
- Library service has volunteers who provide a health information desk and catalogue books.
- There is a volunteer on Charitable Funds Strategy Directorate and a lead governor of the member's council.

The service implemented a robust recruitment structure to ensure all volunteers are trained and DBS checked to comply with legal and moral obligations to ensure volunteers, service users, stakeholders and services are safeguarded.

The volunteer policy has been amended to accommodate the growth and development of the service and a lone working section was introduced to ensure volunteers in the community had safe working practices and contacts with their manager.
The age of the volunteer was lowered from 16 to 14 (with supervision) to accommodate requests from CAHMS services. The volunteer service and the volunteer's roles are evolving to meet the changes of the extreme pressures on the NHS and as a Trust we listen to what our services are asking of us.
Our achievements and progress in 2017 have been huge and widespread across the Trust further information on our achievements can be obtained from the Volunteer service.

Overall we have seen an increase in numbers of Volunteers, more diverse volunteer roles, better processes and structure around the recruitment process, NCVO uses our accreditation assessment as an example of good practice for their training, we provide advice to other NHS organisations, introduced more courses in Recovery colleges, we have youth volunteers linking with Huddersfield University, more involvement with services, Volunteer stories, Network sessions for volunteer coordinators to provide support and resource, two Excellent awards in first two years for new initiatives, more employment for volunteers.

Above are a few examples of the volunteer commitment, and the support they provide for the organisation. In each individual situation the volunteer's role is different - but everywhere the aim is the same: to coproduce, complement and enhance our service offer and provide opportunities for the individual volunteer.

The next stage requires information from EMT and the services on what they want from our service.

The outcomes will help us to better align our service with the strategic objectives of the organisation to: create a comprehensive investment programme to deliver the Strategy in an effective, accountable way, to build relationships with outside partners, CCG, GP Practices, increase the opportunities to involve volunteers in the strategic part of the organisation, provide more lived experience volunteers and expand the befriender /buddies roles.

We need to introduce a CRM system to enable the service to provide information on the recruitment process to volunteer coordinators and managers, provide training reports and have a page highlighting volunteer stories, news events and up to date information.

We need to enhance the monitoring systems and an investment in highly skilled volunteer coordinators is critical as this plays a major part in assessing the boundaries of volunteers on a regular basis. Matching the right volunteer to the right role is important for the volunteer and the service to ensure consistency. It would also provide up to date information to the central volunteer service through regular meetings with coordinators.

We need to provide training for the volunteer supervisors/ coordinators as more supervisors are clinical staff. More development needs to be done in our communities, especially our minority communities which are diverse with different faiths and origins.

We need to motivate and encourage our existing volunteers to ensure they feel valued and committed, the volunteer celebration day should happen in national volunteer week 1-7 June. There needs to be more promotion of the volunteer service at ward level. NHS 70/70 needs to include a celebration of our volunteers.

Finally we need to ensure that all of the work volunteers do is relevant and of a high quality to build a reputation of excellence, ensuring the Trust maintains a credible reputation of embedding volunteers in its foundations.

C4. Nursing strategy

The nursing strategy describes how nurses can work together to deliver high quality, safe, effective care with compassion. It describes how all nursing staff have an important part to play in improving patient experience and delivering our Trust's vision and values.

The strategy was developed utilising information from a variety of sources including consultation with registered nursing staff, and those in nursing support roles at all levels and non-nursing disciplines across the organisation. This was achieved through discussions with groups in team meetings and ward handovers, use of an online consultation questionnaire, individual interviews and email responses. In addition, a number of key strategic documents have informed its development. It supports the national nursing strategy "Leading Change, Adding Value"
Delivery is supported by an action plan which will be refreshed annually and is monitored through the nursing quality group (NQG). The NQG has met regularly and has representation from the nursing directorate, nurse consultants, quality leads and all business delivery units.

Achievements to date are:

- A senior nurse support system has been developed to support newly qualified nurses.
- Professional appearance policy has been introduced into the Trust
- A number of new roles are being introduced across the Trust, i.e. Nursing Apprentice role, Trainee Nursing Associates, Advanced Nurse/ Clinical practitioner roles.
- Improved opportunities for nurses to engage in higher education, i.e. new MSc course supported through identification of practice learning capacity and District Nursing National apprenticeship programme
- All BDU's have identified 3 local priorities for action against nursing strategy.

The Nursing Strategy is to be reviewed during 2018 and the new strategy will be an integrated nursing and allied health professions strategy.

C5. Allied Health Professional Strategy

Allied Health Professions into Action (NHS England, 2017) is a product for leaders and decision makers, to inform and inspire the system about how AHPs can be best utilised to support future health, care and wellbeing service delivery. It offers a framework to develop a plan of delivery and gives the authority to act. It is collective agreement which describes and demonstrates that AHPs are ready, prepared and have the skills to deliver what is required in an emerging and flexible system.
'AHPs into Action' defines how AHPs can support Sustainability and Transformation Plans (STPs) implement the triple aim set out in the Five Year Forward View; driving improvements in health and wellbeing, restoring and maintaining financial balance and delivering core quality standards.

In summary, 'AHPs into Action' describes the:
• **impact** of the effective and efficient use of AHPs for people and populations
• **commitment** to the way services are delivered
• **priorities** to meet the challenges of changing care needs.

In order to implement the recommendations from this national strategy, SWYPFT AHP Professional Leads produced a paper which summarised the key impacts, commitments and priorities identified in the AHPs into Action strategy, benchmarked the AHP's current position in SWYPFT against these and identified actions required to drive forward the AHP agenda within the organisation. It was also vital that they aligned with the priorities for the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and West Yorkshire and Harrogate STP. This will ensure that the AHP impacts, commitments and priorities are embraced and embedded within the Trust's culture and strategies.

The paper aimed to help the BDUs and STPs to identify their priorities for AHPs, particularly when developing their annual plans.

The SWYPFT AHP plan was approved by EMT and disseminated in to the BDUs. The AHP Professional Leads are supporting managers with the implementation of the plan, commencing with addressing AHP workforce issues via the BDU Workforce planning events.

We have already seen an improvement in recruitment to AHP posts (physiotherapy, speech and language therapy) by implementing new Band 5 to Band 6 development posts. We also now have a master vendor contract for AHP agency staff. This improves quality by ensuring there are AHPs in post to deliver clinical care.

We have expanded the use of technology in children's speech and language therapy where electronic tablets are now being used to assess communications skills.

The AHP Leads are also working with the regional groups to develop Regional AHP Strategies.

These are outlined in the AHP Action Plan and include:

- Increasing access to services through single point of access, self-referrals and AHP Led clinics (e.g. fall clinics, feeding clinics and coeliac clinics in primary care)
- Expanding the AHP role to undertake diagnostic tests (e.g. ultrasounds, X-rays)
- Extending AHP training for staff (e.g. enablement, health promotion, falls and nutrition screening in care homes), service users (e.g. DAPNE) and parents (e.g. early years).
- Further developing AHP Band 7 Advanced Practitioner and Consultant AHP roles via the Trusts Advanced Clinical Practitioner initiative and increasing the number of AHP prescribers in the Trust.
- Increasing the AHP workforce, to overcome workforce undersupply in the nursing and medical professions in both traditional roles and non-traditional roles (e.g. Mental Health Practitioner posts)
- Continuing to be a high quality provider of student placements to enhance future workforce supply.
- Extending the use of technology to offer alternatives to clinic appointments (e.g. telephone/Skype consultations), using tele-monitoring and relevant apps with service users.
- Ensuring clinicians consider both physical and mental health needs, not just single element of care and fostering a self-management approach to prevent relapse.
- Ensuring all AHPs record timely and accurate information on the clinical records system to meet the data requirements of the organisation and professional standards.

What next?

The quality initiatives, in the CARING domain, we will undertake in 2018/19 to help us achieve our aim 'to improve and be outstanding' are improving staff wellbeing, improving patient experience, improve the

customer service offer, develop an integrated nursing and professions service offer, implement the medical workforce strategy and continue with volunteer opportunities.

Priority 4: RESPONSIVE

Why did we focus on this?

By responsive, we mean that services are organised so that they meet people's needs.

'RESPONSIVE' quality initiatives in 2017/18

The following quality initiatives were prioritised for action in 2017/18 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-40.

R1. Improved access to psychology for adults of working age

When CQC visited the service in March 2016, they found that there was not equitable access to psychological therapies across all localities or that this was provided in a timely manner. They asked us to take action in our Kirklees assertive outreach team and Barnsley mental health services.

CQC found that waiting times to access psychological therapies was high. In Barnsley the average wait was 54 weeks. Psychological provision to the South Kirklees Assertive Outreach Team was also insufficient. The expected targets are that people will be assessed within six weeks of referral and where appropriate will receive treatment within 18 weeks from their time of referral.

Between December 2016 and February 2017, CQC re-visited our core services to follow-up on those services that had been rated as requiring improvement to check if the must and should do's from the previous inspection visit had been satisfactorily completed. However, they did not re-visit our Community based mental health services for adults of working age, possibly because they received an overall good rating. However, we anticipated that CQC would return to look at the issue in relation to accessing psychological therapies at some point.

A review of the position in relation to access to psychology was undertaken as part of our internal quality monitoring visit programme.

The latest figures for psychological therapies waiting times from referral to assessment and those for assessment to treatment were reviewed from Barnsley and South Kirklees and the findings are outlined below.

When CQC visited the service in March 2016, they had concerns that in Barnsley CMHT, the average waiting time from referral to the first date of therapy was 54 weeks with the maximum wait 76 weeks.

Since CQC last visited and through the transformation changes, Barnsley has two waiting lists. The first is between the point of referral and the initial stabilisation-focused psychological interventions (see below) which are categorised as the referral to assessment waiting times. The other waiting list is for more traditional psychological therapy that is classed as the wait time from referral to therapy.

Barnsley:

- Psychology waiting times in the Barnsley Enhanced teams have been successfully eliminated.
- A new psychology pathway has been introduced into the Barnsley Core Mental Health Service.
- Referral rates to Core Psychology have been 66% higher than were expected pre-transformation.
- The wait for a first assessment appointment within the Core Psychology service has remained relatively consistent over the last 6 months at an average of 17 weeks.
- The number of people waiting for psychological therapy within the Core Psychology service has reduced. Some of this drop is likely to be to do with the different service offer for newly referred clients.

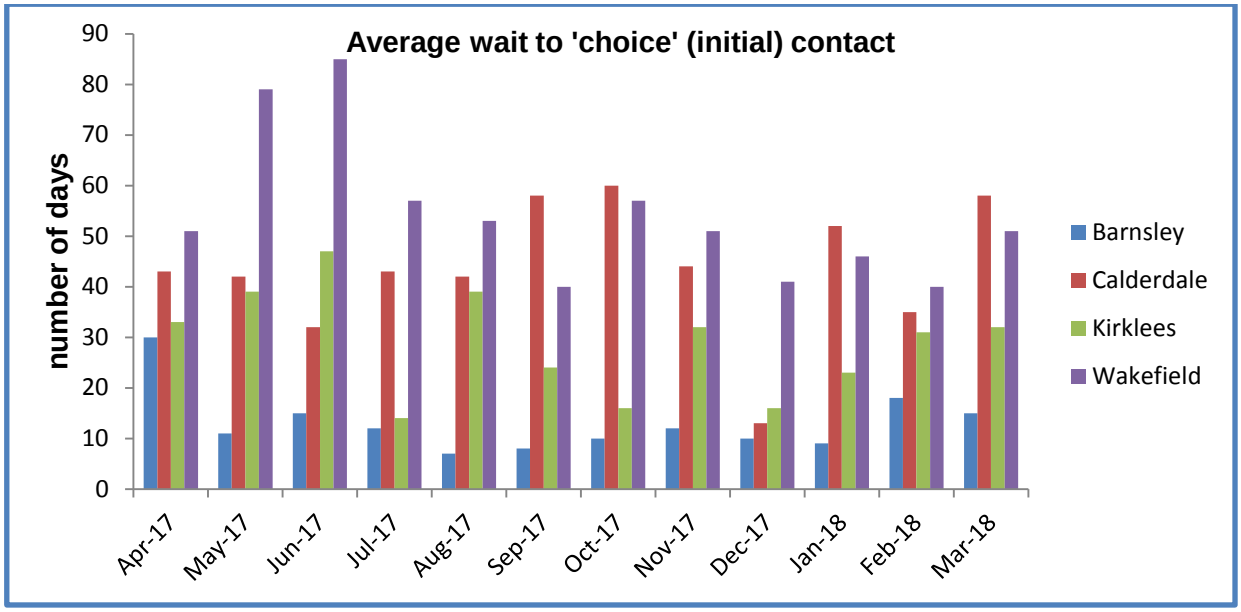
- The worsening in waiting time for intensive intervention is partly due to the new pathway which means more appointments are offered to new referrals in order to deliver the stabilisation work, meaning fewer appointments are available for intensive intervention. Hence whilst this has been successful in significantly reducing the flow of people onto the waiting list for intensive interventions, and so achieving its aim of bringing our service more into capacity, it has had a negative short-term impact of increasing the amount of time those currently waiting would have had to wait under the old pathway.
- Despite improvements in the overall numbers, it is unlikely that waits will be significantly reduced without additional capacity to address the backlog.

Discussions with the CCG are ongoing to help us address the waiting times.

Within South Kirklees CQC reported that provision of psychological therapies to their assertive outreach team was insufficient. Since that time the service has undergone transformation and this has led to the psychological therapy resource being allocated to both the Enhanced and Core Pathways.

R2. Improved access to CAMHS generic team

The waiting time to initial assessment data is set out below, however this information is now of limited reliability and relevance given changes to service pathways. With introduction of single point of access (SPA) arrangements in each area initial assessment is increasingly taking place at the point of referral (telephone based) and where possible brief interventions are being offered as soon after the assessment as possible. During 2018/19 we are developing our reporting systems to reflect this change as the data below conflates initial assessment and first intervention.



Once a child or young person has had a choice assessment, in our traditional pathways, they then go on to wait for treatment. Waiting times in Barnsley and Wakefield remain far too long. In Barnsley both the total number of children and young people waiting and those waiting for more than 6 months are increasing. A number of features/factors should be noted in regard to waiting times;

- There is no nationally mandated waiting time for CAMHS interventions. In the absence of a specific standard a proxy of 18 weeks from referral to commencement of treatment would seem reasonable. In Barnsley 358 children and young people have already been waiting for more than 18 weeks. This figure is 218 in Wakefield, 10 in Calderdale and 10 in Kirklees.

- A significant factor in addressing waiting times in Calderdale and Kirklees was the additional investment in establishment of a dedicated crisis and home based treatment team and the commitment made by SWYPFT as a 'cost pressure'. Improvement was subsequently given further impetus through establishment of strengthened SPA arrangements.

R3. Improved access to specialist assessments and interventions in our community teams for people with Learning Disability (LD)

Following a CQC Inspection in 2016, one of the "must do" areas as an outcome of the inspection for Learning Disability Community Health Teams was to ensure we have well managed waiting lists. Since then, the Service has undertaken a great deal of work to improve this activity. Below is an overview of actions that have been taken and the current position of where the four localities – Barnsley, Calderdale, Kirklees and Wakefield LD Community Health Teams are with the management of their waiting lists.

When community services for LD were originally inspected, Calderdale were newly formed single multi-disciplinary health teams and Wakefield and Kirklees were split teams with the nursing service integrated with the local authority in Wakefield and nursing and allied health professional services integrated with the local authority in Kirklees. Since then we have;

- Brought all our services under Trust line management
- Transformed provision into single community health teams in all 4 localities
- Ensured all disciplines are recording on the same system
- Created single points of access in all 4 localities
- Developed a shared allocation process with local authority representation to ensure that all referrals are considered by representatives from all multi-disciplinary health and social care teams
- Created shared access criteria that takes individual discipline provision
- Introduced an initial screening process that has been completed before a referral is submitted to allocation. This ensures that where referrals do not meet the access criteria (e.g. the need can be met by a mainstream service), these are signposted without the client needing to wait
- Where referrals are made and needs can be met by more than one discipline in the team, the referral is picked up by the discipline with the least number of clients already waiting for a service
- Where referrals are made to receive a multiple discipline service and it has been allocated by one discipline and not the other, the professional who the case is opened to is mindful of ensuring needs do not escalate whilst the client is waiting for another discipline involvement
- All staff are clear that the time between the referral and provision of a service should not exceed 18 weeks and leads have a process in place to monitor and manage this to reduce breaches where possible
- Senior management team monitor waits across each locality monthly and this information is disseminated through Operations Managers to leads in each locality
- The system is set up to ensure we have a transparent method of showing who is waiting for service and who a client is opened to. This helps staff and managers to access full information about who a client is opened to and what discipline services they are waiting for. Whilst a client may be open to one discipline and waiting for another, we work as a single team in meeting needs so the client is not classed as waiting for a LD community health team service

- Commissioners have introduced key performance indicators (KPIs) that we report on monthly. Within our KPI reporting, we have an indicator that measures referrals being placed on the system within 24 hours of receipt and another that measures routine referrals being screened within 2 weeks of receipt and another indicator that measures cases receiving service within 18 weeks of receipt. Outcomes of these KPIs are measured by Performance and Information Team and shared with our leads so that they understand and discuss what issues we have with specific cases in quarterly Performance Clinic meetings.

The data below shows our senior management monitoring tool that ensures we retain an up to date knowledge of cases waiting for an LD Service:

Locality waiting lists broken down into individual disciplines	**On W/L: Waiting More Than 18wks** (cases that have **breached** BUT maybe on the caseload of another discipline)	**Not Open to Other Disc: Waiting 6 weeks or Less** **(no breach)**	**Not Open to Other Disc: Waiting 7 to 12 weeks** **(no breach)**	**Not Open to Other Disc: Waiting 13 to 17 weeks** **(no breach)**
Barnsley Community LD Team	**3**	**6**	**1**	**0**
Calderdale Community LD Team	**3**	**1**	**1**	**0**
Kirklees Community LD Team	**37**	**5**	**4**	**2**
Wakefield Community LD Team	**9**	**5**	**3**	**0**
GRAND TOTAL	**52**	**17**	**9**	**2**

As the table above shows we have a hot spot in Kirklees which is due a combination of services managing some out of scope activity whilst commissioners relocate it, vacancies and long term leave.

From a point of not understanding who was waiting for a LD community health service consistently when originally inspected by CQC, we now have a clear and transparent process to know who is waiting for a service and furthermore, what type of service each referral is waiting for. We are aware that we have hot spots and have mitigations against each of these positions. Where we may see an increase in breaches or referrals that are reaching the breach point, we have processes in place to identify and act on this. we will continue to monitor waits in our LD services during 2018/19.

R4. Complaints closed within 40 days

The Trust takes complaints about services very seriously and wants to ensure a response that resolves the issues raised. The Trust is committed to learning lessons from feedback recognising the valuable opportunity to reflect on the care offered and use this as a means of improving.

The Trust adopts an approach to complaints and feedback that promotes resolving issues at service line wherever and whenever this is possible.

The process to ensure robust investigation of issues and sign off of complaints is under review. The current process involves investigators, general managers, service directors, nursing and medical directors as appropriate and the Chief Executive. Given the number of people involved, this can result in delay in offering a response, often exceeding the internal 40 day target.

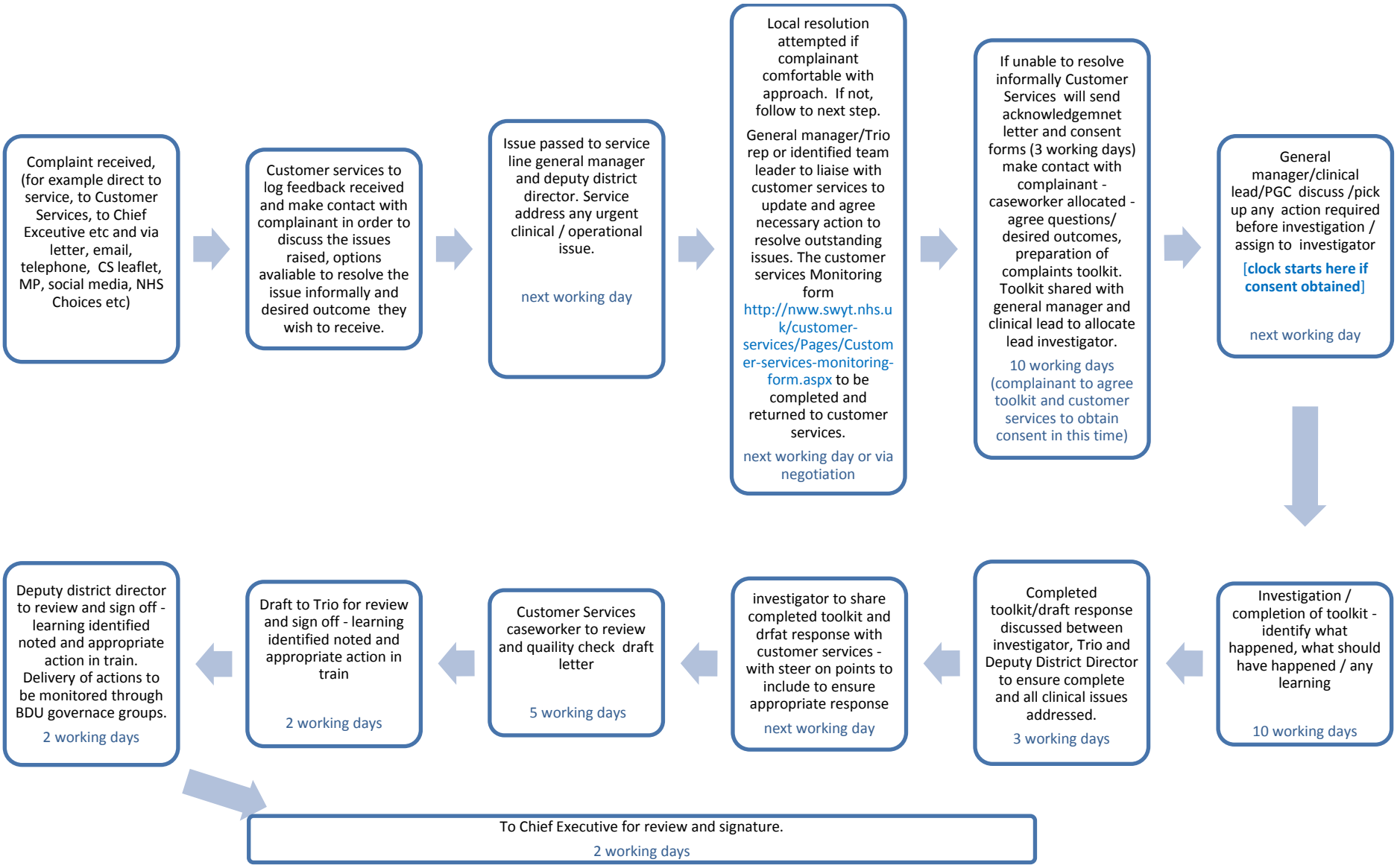
The purpose of the review is to increase ownership of issues at service line and promote a more timely response to the complainant. The Director of Nursing and Quality is leading on this work which is being taken forward through the Operational Management Group. The intention is to introduce steps to ensure service involvement as soon as possible when issues are raised and scrutiny of completed investigation toolkits by services before they are returned to Customer Services. Draft responses will then be prepared in Customer Services. Drafts will be reviewed by services to ensure all clinical issues are identified and addressed and that the investigation has provided sufficient information to enable a full response. Deputy

district directors will then review and sign off the draft response, with a final version shared with the Chief Executive for review and signature.

The initial aim of the process review is to ensure we respond to people's complaints within our internal target of 40 days, with a longer term view to be able to respond to complaints within 25 days by 2020.

The flowchart on page 67 describes the revised process.

Revised complaints pathway (Feb 2018)



R5. Implementation of Freedom to Speak up Guardians (FTSU)

The principles of how the Freedom to speak up guardians would operate were discussed at the end of 2016 and a proposal was made by Director of Workforce, Organisational Development & Estates, to utilise the staff Governors as a network to handle FTSU cases as a pilot, to be reviewed after 12 months. To that end the network was formed and initial familiarisation work around bullying and whistleblowing polies was undertaken.

The first cases came in shortly after the New Year and have been complex in nature and have required substantial amounts of time and commitment to ensure that they were heard and followed through effectively.

Three cases that came to the FTSU guardians were related although they were dealt with confidentially and independently. They were indicative of a workplace environment that felt controlling and pressurised and all three staff members complained of bullying scenarios. The staff were looking for a change in the team atmosphere and dynamics. This was passed on to HR and team building work has been implemented into that unit.

Another case was a whistle-blowing incident where a staff member raised concerns about the safety of a patient who was living in the community. On reporting this, the staff member felt ostracised. It was apparent that he/she did not feel the whistle blowing policy had been taken seriously by the Trust and that the protection indicated in the policy had not been realised in this case. This was referred to Staff side and support was given regarding the implementation of the whistle-blowing policy.

The FTSU network consists of all the staff governors. There are meetings scheduled with the lead director, where we meet to discuss cases, issues, pressures and gain support. We also meet as a team outside of this meeting to share experiences and offer mutual support. We also look at how to best manage the workloads and interact with regional and national bodies

A number of the team has now engaged in regional meetings, national conferences and training. There is also a quarterly report of data collection that is produced and sent to the national guardians' office and incorporated into national statistics.

It has been discussed whether or not the role should be exclusively that of the governors or indeed if there should be another model. From March it has been decided to have 5 hours a week dedicated to the guardians' work in order to help with coordination, information sharing and promotion of the work. This will be evaluated in September 2018.

The table below gives an overview of the 8 cases that have been referred to the FTSU during 2017/18

	Cases raised	Raised anonymously	Element of patient safety / quality	Element of bullying / harassment	Suffering detriment
Quarter 1	4	0	0	4	2
Quarter 2	2	0	1	1	2
Quarter 3	1	0	1	1	1
Quarter 4	2	0	0	2	1

What next?

The quality initiatives in the RESPONSIVE domain which we will undertake in 2018/19 to help us achieve our aim 'to improve and be outstanding' are: To continue with our focus on transitions and access to CAMHS. We will also continue with a focus on access to our services and improving wait times and reduce the number of people in out of area beds and implement the Equality and Inclusion strategy.

Priority 5: WELL LED

Why did we focus on this?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

'WELL- LED' quality initiatives in 2017/18

The following quality initiatives were prioritised for action in 2017/18 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-40.

W1. Quality dashboard (integrated performance report)

Good quality information is a driver of performance for clinical teams and helps ensure the right services and best possible care is provided to service users.

A 'quality dashboard' is a toolset developed to provide clinicians with the relevant and timely information they need to support daily decision making that improves quality of service user care. A dashboard gives our clinicians easy access to the wealth of data that is being captured locally, in a visual and usable format, whenever they need it.

The first step we took in the development of the quality dashboard was to identify metrics that we already collected, that could be reported monthly in the quality section of our integrated quality report. We aligned the metrics to the Trust objectives and CQC domains and allocated each metric a director level 'owner'. This ensures there is appropriate accountability for the delivery of all our metrics and helps identify how achievement of our objectives is being measured.

The work on the quality dashboard will continue to develop in 2017/18. We are looking to identify and develop more measures that will give us additional information on the quality of clinical care, for example, 1:1 contact time (between nurse and service user) in our inpatient areas.

W2. Quality Scheme

The Quality Scheme is designed as an accreditation tool that is intended to help teams to recognise their strengths and any areas where improvement is needed. When CQC re-visited the Trust during December 2016 to February 2017, they changed our overall rating from 'requires improvement' to 'good.' The aim of the Quality Scheme is to sustain the good quality and safety of our services and to improve further so that we become an outstanding service for our service users.

The aims of the Quality Scheme are:

- To improve the standards of quality care and safety within teams and services.
- To develop and embed our organisational culture of quality improvement.
- To provide a framework so that teams can focus on quality standards, self-assess and monitor their own standards and be used as part of their governance processes.
- To enable teams to reflect on their effectiveness and to be aware of areas where improvement is needed.
- To recognise and reward those teams that are providing consistently high standards of care and are sustained.
-

The principles of the Quality Scheme are as follows:

- To put our service users at the centre of everything we do.
- To improve on our existing standards and to keep getting better at what we do.
- To recognise and celebrate excellence.
- To demonstrate commitment to quality improvement.
- To use the Quality Scheme to share best practice

The introduction of the Quality Scheme is intending to have the following benefits:

- It will enable teams to be able to more closely monitor their performance.
- It will make their quality assurance systems more robust and will help them to identify their strengths and areas for quality improvement.
- It will empower teams to have ownership of their daily working practices and control over how they can impact and influence these.
- It will be a driver for developing teams and services to be outstanding.

The standards are aligned to the CQC fundamental standards.

There are 12 standards and each one is based on current evidence of best practice, national legislation, and regulatory guidance.

Evidence will be obtained from a range of sources which will be triangulated to provide robust, meaningful verification of the standard of care being delivered and ultimately to substantiate gold standard care worthy of recognition and accreditation.

The Quality Scheme will use a variety of approaches to look at quality standards including:

- 10 service user questionnaires
- 10 staff questionnaires
- A variety of documentation
- Quality dashboard data
- Observation of the environment

Each standard has evidence measures which will result in a percentage score. The overall percentage score for each standard will be the mean (average) of all the evidence measure scores within a particular standard. The rating for each of the standards will be determined by the following:

- Gold=The mean score is 80% or greater
- Green=The mean score is between 50%-79%
- Red=The mean score is less than 50%

Each standard is given a rating and then the overall team rating will be determined by the total number of gold, green and red standards.
The visit team will usually consist of at least four members from varying backgrounds. The visits will normally last between 4-6 hours. The visit team will use standard tools to look at the evidence submitted from teams.
Teams that achieve a gold rating will receive recognition of this.

Quality process

Step 1

Undertake self-assessment to establish a baseline score
Using the Quality Scheme Tool, with the support of the Quality Improvement & assurance Team

The findings of the self-assessment will determine the next step

Step 2

Overall Gold	Overall green	Overall red
Submit application for quality scheme assessment	Action plan drafted to enable achievement of **Gold** status and may submit formal application	Action plan drafted to enable significant care deficits to be addressed and progression to Green status

Step 3

Following a **formal application for quality scheme assessment**, the Inspection Team will request specific evidence and schedule a half day inspection of the team

The findings of the formal assessment will determine the next step

Step 4

Overall Gold	Overall green	Overall red
The Inspection Team will make a recommendation to the Quality Scheme Panel based on the evidence	Formal action plan drafted to enable achievement of Gold status. **Formal re-inspection in 6-12 months** The ward will be designated ***Green working towards gold***	Formal action plan drafted to enable significant care deficits to be addressed and progression to Green status **Formal re-inspection in 3-4 months** Progress will be monitored by DN&Q

Step 5

The Ward Team present their evidence to the Quality Panel who will make the final decision to award Quality Scheme Accreditation

Re-assessment annually thereafter to maintain accreditation

W3. Quality improvement toolkit

In 2017/18 we set the development of a toolkit as a quality priority .whilst some progress has been made on the toolkit , this work is dependent on the quality the Trusts Quality Strategy, which was approved by Trust Board in March 2018. With the approval of the strategy the work on the toolkit can now progress throughout 2018/19.

W4. Do and share improvements

'Do and Share' improvements is the name we give to improvements that are low cost, low risk and low complexity and usually are initiated in one team or service line. In most cases they are initiatives that can be implemented quickly and shared across the trust for maximum effect. The I hub is a platform where we can create 'do and share' ideas. From 2017/18 there were 376 ideas posted on i-hub, with 2236 comments and 6033 votes. There were 30501 views of posts people have made, 959 page views and 590 people joined during this period, with a total of 1770 people joined to date. This would suggest significant do & share activity. The 376 ideas posted are a mix of new ideas across the range of key challenges, and shares of fab/good practice, along with campaigning posts for calendar events such as dieticians week, work out at work week etc.

Many of the ideas find a natural home- and we connect the person with someone who can help/might already be doing something similar and they take it forward. There are also lots of new ideas which get adopted and go live. Some are shares of good work- not new ideas- so we celebrate these and add words of encouragement. The platform also helps connect people with requests for others to join a project.

During 2017/18 we also ran a number of key challenges, for example, we used the platform to share ideas, key messages and gather ideas in relation to our flu campaign. We also ran an internal innovation event to celebrate 'do and share' in July 2017, and had a visit from Roy Lilly and the Academy of Fab Stuff in August, which helped in supporting staff to do and share/improve.

What next?

The quality initiatives in the WELL- LED domain which we will undertake in 2018/19 to help us achieve our aim 'to improve and be outstanding' are: implementation of the quality scheme, complete the work on the quality toolkit, continue to improve the culture of 'do and share' activity, increase the number of people who have undertaken bronze quality improvement training and implement the SO WHAT – trust wide learning lessons framework.

Annexes

Annex 1 Glossary

BDU	**Business Delivery Unit**: The Trust runs services on a district by district basis with support from a central core of support services. These district management units are called Business Delivery Units (BDUs). We have six BDUs; Barnsley, Calderdale, Kirklees, Wakefield and Forensics and Specialist Services.
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CPA	**Care Programme Approach CPA:** CPA is the framework for providing care for mental health service users
CQC	**Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. They look at the joined up picture of health and social care. Its aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation.** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (the NHS next stage review report) of an NHS where quality is the organising principle.
DATIX	**Datixweb** is the web based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
DOH	**Department of Health:** The Government body responsible for delivering a fast, fair, convenient and high quality health service in England.
DTOC	**Delayed transfer of care –** occurs when a service user is ready for transfer from acute care, but is still occupying an acute bed.
FFT	**Friends & Family Test:** a service user experience and quality improvement tool used across the NHS
IG	**Information Governance** ensures necessary safeguards for, and appropriate use of, patient and personal information.
MSO	**Medication Safety Officer**
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
POMH	**Prescribing Observatory for Mental Health**
RiO	The electronic service user record system that is used in mental health services

Annex 2: Statements from our stakeholders

1. Wakefield Overview & Scrutiny Committee

Through the Quality Accounts process the Adults Services, Public Health and the NHS 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. This included a dedicated session with the Trust on the 12 April 2018.

The committee agrees with the Trust's decision to align its strategic objectives, priorities and programmes and quality initiatives within a framework of improvement 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.

The Committee accepts that the content and format of the Quality Account is nationally prescribed. The Quality Account is therefore having to provide commentary to a broad range of audiences and is also attempting to meet two related, but different, goals of local quality improvement and public accountability. The Committee believes that the Trust has generally managed to achieve this process in the development and production of the Quality Account.

However, In order to make sense of information presented requires the provision of standard, consistent and comparable measures, published in a format that enable interpretation and comparison. Priorities for improvement should then be given benchmark or trend information to provide some context for interpretation. Whilst the Quality Account is compliant with statutory requirements and published guidance it is difficult for the public to make informed choices in the absence of comparable data with other mental health providers, for example. The Committee considers that one of the most important elements for the audience of quality accounts is comparative performance against peers or a national average, or target or a standard, because it is generally not possible to interpret information on quality without benchmarking against a comparator.

It is difficult for the Committee to make comment on particular areas of the Quality Account when it is still in draft. This is particularly evident in relation to learning from patient deaths where information on case record reviews and investigations has yet to be completed, including data in relation to patient deaths during the reporting period that are judged to be more likely than not to have identified problems in care provided to the patient. This is particularly important in relation to people with learning disabilities in order to understand why people with a learning disability typically die much earlier than average, and to inform a strategy to reduce this inequality.

The Committee welcomes the Trust's overall approach to quality improvement which occurs as near to service users as possible. The development of skills for improvement, robust quality assurance and strong clinical governance will underpin the approach to setting quality as the organising principle for the Trust's services.

The Committee supports any actions to reduce the number of service users who require out of area bed usage, in line with the principle of caring for people as close to their locality as possible. It is well known that this aspect of quality is important to patients, carers and families.

The Committee welcomes the continued emphasis on the suicide prevention strategy implementation. The Committee will look in detail at the quality of the strategy and how effectively it is being implemented over the next year.

The Committee welcomes any priority for integrating physical and mental health, particularly promoting health among people with severe mental illness and supports measures to routinely undertake physical health assessment and treatment for people with serious mental illness, but would also like to see a similar commitment for people with learning disabilities included as a quality priority.

The Committee notes the reference in the Quality Account regarding the Transitions out of Children and Young People's Mental Health Services and the actions being put in place to promote safe and smooth transitions for children and young people, their families and carers who utilise the Trust's services. The experience of patients is a well-accepted marker of quality so the commitment to improve the outcome of the friends and family test in relation to CAMHS is welcome.

The Committee notes that 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.

The Committee has previously focussed on staff engagement and has noted the results from the 2017 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. It is therefore disappointing that the Trust's indicator of staff satisfaction with the quality of work and care they are able to deliver has reduced slightly in 2017 as opposed to the previous year.

The Committee supports the framework for the Trust's quality priorities which are now aligned to the 5 domains of the Care Quality Commission: Safe; Effective; Caring; Responsive and Well-led. This framework should allow improvement priorities to be more explicitly aligned to the Trust's core values that reinforce behaviours and ways of working in order to underpin a culture of service improvement and better quality care.

The Committee is grateful for the opportunity to comment on the Quality Account and looks forward to working with the Trust in reviewing performance against the quality indicators over the coming year.

2. Clinical Commissioning Group (Calderdale, Kirklees & Wakefield)

Statement presented by NHS Calderdale Clinical Commissioning Group (CCG) in conjunction with associate commissioners from NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Wakefield CCG.

South West Yorkshire Partnership Foundation Trust (SWYPFT) 2017/18 Quality account statement.

Thank you for providing the South West Yorkshire Partnership Foundation Trust (SWYPFT) Quality Account 2017/18 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 organisational context for how this is managed and the Trust's quality ambitions. The Quality Account is well constructed and has a flow throughout, using the 5 domains of Safe, Effective, Caring, Responsive & Well Led (Care Quality Commission) as a framework to organise the quality improvement priorities.

We are pleased that the Trust has attained a high number of quality standards and this is demonstrated though the increased achievement of CQUINS (Commissioning for Quality and Innovation) goals this year compared to previous years.

The Trust is also open about areas of underachievement, for example complaints closed within 40 days and Child and Adolescent Mental Health Services (CAMHS) Friends and Family Test (FFT) results. Performance against these indicators is discussed at the Quality Board along with plans for improvement.

We note with interest the Quality Scheme which has been designed as a self-assessment accreditation tool to help teams recognise their strengths and any areas where improvement is needed, and we would welcome future discussions about this initiative at the Quality Board. The 'Do and Share' improvement scheme is also noteworthy and appears to be a successful way of sharing simple quality improvement projects and connecting people working on similar agendas.

We have also noted the innovative approaches the Trust have adopted to try to improve the response rates for FFT. Of particular note is the work Calderdale and Kirklees BDU (Business Development Unit) have done to improve response rates by introducing a minimum number of responses per team that should be collected on a monthly basis. The BDU have seen a significant improvement in response rates.

As commissioners we welcomed the opportunity to be involved in some of the quality monitoring visits within the Trust and look forward to ongoing participation with this programme of work. This Quality Account would have been strengthened with some inclusion of the findings and actions agreed.

There are a number of sections in the Quality Account that have been well described in terms of process, but we feel they could be improved with specific examples of work that has been completed as a result, for example:

- *Clinical audit* - it would have been useful and relevant to give examples of improvements implemented as a result of the audit findings.
- *Mortality review process* – providing specific examples of the learning would have been helpful.
- *Out of area placements* – we are aware of the substantial work being done at West Yorkshire level that SWYPFT are contributing too. More narrative about this programme of work would help to understand how the risks are being mitigated.

It is really encouraging to read about the Allied Health Professional (AHP) Strategy and how this has being used to benchmark the AHP's current position in SWYPFT and drive forward the AHP agenda within the organisation. We would welcome future discussions about this work at the Quality Board.

The work streams under Sign up to Safety continue to show good achievements and the work done to embed the falls screening tool is commendable, particularly in the older people's inpatient areas.

We as commissioners were invited to be involved in an audit to review the quality of care plans. We have been involved in this audit for a number of years and it is pleasing to see further improvements in the quality of care plans.

Finally, this account contains some good examples of partnership working across sectors and academia with a particular focus on the development of skills for improvement. There are still challenges ahead but we feel SWYPFT have identified the key areas for improvement and we look forward to working closely with the Trust over the coming year and support the realisation of the quality improvement priorities set out in the account.

3. Calderdale& Huddersfield NHS FT

18 May 2018
Tim Breedon
Director of Nursing & Quality
Trust Headquarters
Fieldhead Hospital
Wakefield
WF1 3SP

Dear Tim
Thank you for your letter of 10 May 2018 and the full and positive response you have made to our draft Quality Account for 2017/18.
We will continue to work with our partners to maintain our commitment to compassionate care and promote our shared values.
Kind regards

Owen Williams
Chief Executive

4. Health Watch Wakefield

Healthwatch Wakefield is pleased once again to comment on the Quality Account of the South West Yorkshire Partnership NHS Foundation Trust ('the Trust') for the year 2017/2018. We are pleased to report that the Trust has continued to involve Healthwatch Wakefield on a number of issues.
At the time of writing the opening statements on quality from the Chief Executive and the Chair were not available, so we are not able to provide commentary on that part of the account.
Whilst we have concerns that results in a few of the priorities for 2017/18 fell short of expectations (3 out of 32 were rated 'Red') it remains encouraging to note good performance in many other areas (26 out of 32 rated 'Green'): this is an improvement on 2016/17 and we are delighted to see progress being made.
We are also pleased to see that the core services, as inspected by the Care Quality Commission, retain their overall 'Good' rating following inspections in March 2018. Healthwatch Wakefield would continue to welcome further progress being made in these services, especially in the two key domains (Community Mental Health services and Acute Wards) that remain rated as requiring improvement.
In terms of the specific priorities as outlined in last year's Quality Account, Healthwatch Wakefield commend the Trust in regards to the results achieved in many areas., with further commentary and detail on each area as follows:

Quality Domain: Safe

Good results this year across the board in this domain, including in improving the physical health for patients with severe mental illness and communicating with General Practitioners (again an improvement on 2016/17).
It remains hugely encouraging to see good performance in staffing fill rates, both Registered Nurse and overall staff levels, however we would continue to welcome further improvements relating to both pressure ulcer prevention / management, and the prone restraint incidents.

Quality Domain: Effective

Much more consistently positive results here compared to 2016/17, and it is heartening to see opportunities to continue to improve being taken, especially in relation to improving CQUIN goals around transition from CAMHS to Adult services.

Quality Domain: Caring

Friends and Family Test results for Community Health, Mental Health and Trust wide Services are now good, following improvement initiatives taken over the last 12 months. Attention still needs to be paid to improving these scores in CAMHS, wherever possible.

Quality Domain: Responsive

Healthwatch Wakefield has concerns regarding the rate of complaints closure within 40 days – this target has been consistently missed throughout the year, and we would welcome urgent action being taken to address and improve this area. We note the points outlined on page 66 and the revised process described on page 67 of the report, and look forward to seeing the benefits of these revised initiatives.

Quality Domain: Well Led

We are pleased to see good results in relation to the quality dashboard, improving clinical information and CQC action plans, as well as the development of a quality improvement toolkit.

Quality Priorities for 2018/19

The priorities detailed on pages 5 to 13 outline the extent of the individual pieces of work that will take place over the next 12 months to support quality improvements across all of the Trust's services. Of the many initiatives listed here, a number have been selected to be the key priorities for 2018/19.

The forward priorities have again been clustered against CQC quality domains (Safe, Effective, Caring, Responsive and Well Led) and a total of 31 areas have been prioritised. Retaining consistent and effective focus on this many is likely to be difficult and we would therefore again urge the Trust to ensure that sufficient ongoing monitoring and reporting practices are in place throughout the year to ensure nothing is neglected.

Healthwatch Wakefield is encouraged to note that those priorities from 2017/18 against which the Trust underperformed have been retained for 2018/19. We will be happy to continue to support the Trust in achieving continuous improvement in any way we can throughout the year.

Overall Summary

The draft document that was presented to Healthwatch Wakefield for review is well-designed and comprehensive. We particularly like the summary of performance against 2017/18 priorities which is then followed by a section with further detail for those who need it.

However, Healthwatch Wakefield Task and Finish Group members have raised concerns regarding the accessibility of this document. All NHS and Adult Social Care organisations are required to have an Accessible Information and Communications policy within which they should identify when and how they will provide information and communicate in alternative formats.

The Quality Account annual reports need to be made available to the public, and the Trust should decide what actions they wish to take to proactively or reactively publish documents in alternative formats. Good practice would be that an accessible summary of the account should be made available in at least one other format: indeed, we are aware that other Trusts produce the information in easy read alongside the original report, and we would recommend that South West Yorkshire Partnership NHS Foundation Trust take at least the same approach.

Annex 3: 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.

NHS Improvement 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 2017-18 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 2017 to March 2018
    - papers relating to Quality reported to the Board over the period April 2017 to March 2018
    - feedback from commissioners dated 23 May 2018
    - feedback from local Health watch organisations dated 23 May 2018
    - feedback from Overview and Scrutiny Committee dated 18 May 2018
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2017 (Q1), Oct 2017 (Q2), Dec 2017 (Q3) and March 2018 (Q4).
    - The national community mental health patient survey 2017
    - The national staff survey 2017
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 25 May 2018
    - CQC Inspection report dated April 2017.
- 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 NHS Improvement annual reporting manual and support guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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 Date 25 May 2018 Chair

Date 25 May 2018 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 2018 (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 2018, 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 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early Intervention in Psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral; and
- Inappropriate out of area placements for adult mental health services.

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 NHS Improvement.

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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below; 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'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance, 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 the documents listed below:

- Board minutes for the period April 2017 to March 2018;
- papers relating to quality reported to the Board over the period April 2017 to March 2018;
- feedback from Commissioners, dated 17/05/2018;
- feedback from local Healthwatch organisations, dated 23/05/2018;
- feedback from Overview and Scrutiny Committee, dated 18/05/2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated June 2017 (Q1), Oct 2017 (Q2), Dec 2017 (Q3) and March 2018 (Q4);
- the national community health patient survey 2017;
- the national staff survey 2017;
- Care Quality Commission inspection report, dated 13/04/2017; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 25/05/2018.

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.

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 2018:

- 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 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' and supporting guidance.

Deloitte LLP
Newcastle Upon Tyne
25 May 2018

Data entered below will be used throughout the workbook:

Trust name:	South West Yorkshire Partnership NHS Foundation Trust
This year	2017/18
Last year	2016/17
This year ended	31 March 2018
Last year ended	31 March 2017
This year commencing:	1 April 2017

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South West Yorkshire Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the accounts direction issued by NHS Improvement, 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 (and the Department of Health and Social Care Group Accounting 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed  …….

Rob Webster Chief Executive Date 25 May 2018

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 25 May 2018

Signed……. ……..…..
Mark Brooks Director of Finance Date 25 May 2018

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

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of South West Yorkshire Partnership NHS Foundation Trust (the 'Foundation Trust') and its subsidiaries (the 'Group'):

- **give a true and fair view of the state of the Group's and Foundation Trust's affairs as at 31 March 2018 and of the Group's and Foundation Trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts: and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Group and Foundation Trust Statements of Comprehensive Income;
- the Group and Foundation Trust Statement of Financial Position;
- the Group and Foundation Trust Statements of Changes in Taxpayers' Equity;
- the Group and Foundation Trust Statements of Cash Flow; and
- the related notes 1 to 38.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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

Summary of our audit approach

Key audit matters	The key audit matter that we identified in the current year was: *Revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care*
Materiality	The materiality that we used for the group financial statements was £4.46m which was determined on the basis of 2% of total operating income.
Scoping	The scope of the audit is in line with the Code of Audit Practice issued by the NAO. All testing of the Group, Trust and Charity was performed by the main audit engagement team performed at the Trust's head offices in Wakefield, led by the audit director.
Significant changes in our approach	In the current year Property Valuations, Agresso Migration and Community Hub Project are no longer considered key audit matters.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Foundation Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care

Key audit matter description

As described in note 1, Accounting Policies and note 1.3, Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to:

- The judgements taken in evaluating volume-related and Commissioning for Quality and Innovation ("CQUIN") income;
- The judgmental nature of provisions for disputes, including in respect of outstanding over performance income for quarters 3 and 4.
- The judgements taken in evaluating contractual services in relation to Barnsley Intermediate Care.

Details of the Group's income, including £167m of Commissioner Requested Services, are shown in note 5.1 to the financial statements. NHS debtors are shown in note 21.1 and 21.2 to the financial statements.

The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. This was discussed by the Audit Committee on page 22 of the Annual Report.

How the scope of our audit responded to the key audit matter

In order to address this key audit matter, we have performed the following procedures:

- We performed a retrospective review of management's estimation techniques used in application and allocation of CQUIN income. , to assess accuracy.
- We have assessed the design and implementation of controls over management's estimation of CQUIN target measures;
- We have obtained evidence that CQUIN income for Q1-3 was agreed between the Trust and the commissioners; and assessed whether the income recognised by the Trust was in line with that which had been agreed;
- We have reviewed the Q4 estimate of CQUIN income and have agreed this to supporting information from the Trust on activity performance;
- We have reviewed the design and implementation of the controls covering the recognition and valuation of debts owed by Barnsley Commissioners. We reviewed correspondence with Barnsley CCG and verified income recognised through to invoice.

Key observations

We consider the income recognised from CQUIN to be appropriate based on the Trust's patient activity and reported performance against the operational targets agreed with the Commissioner. We also consider the income recognised under the Barnsley Intermediate Care contract to be reasonable.

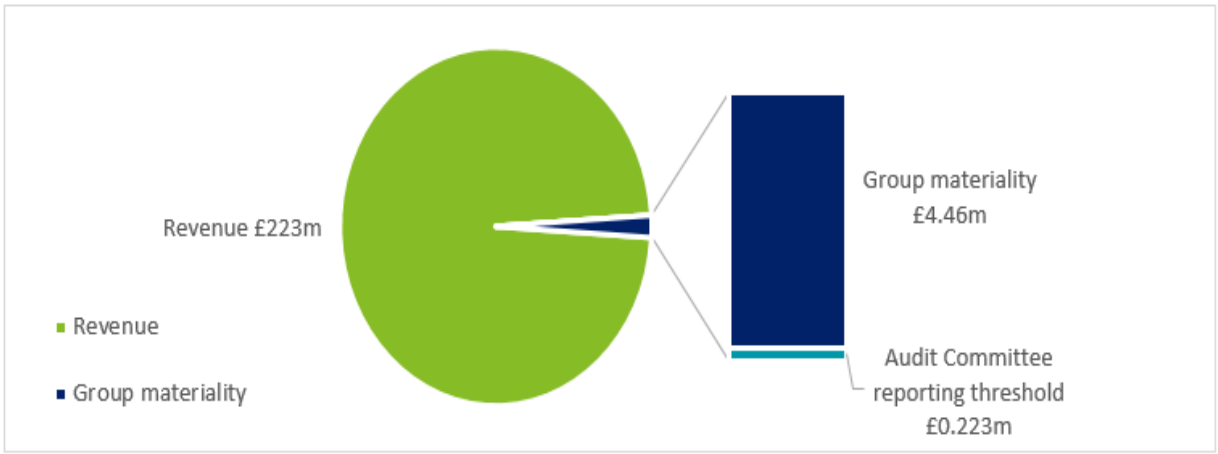
Our application of materiality

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.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements
Materiality	£4.46m (2016/17: £4.6m)
Basis for determining materiality	2% of Total Operating Income (2016/17: 2% of Total Operating Income)
Rationale for the benchmark applied	Operating Income was chosen as a benchmark as the Trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements.

	Foundation Trust financial statements
Materiality	£4.45m (2016/17: £4.6m)
Basis for determining materiality	2% of Total Operating Income (2016/17: 2% of Total Operating Income)
Rationale for the benchmark applied	Operating Income was chosen as a benchmark as the Trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £223k (2016/17: £221k), 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.

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

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 Fieldhead Hospital directly by the audit engagement team, led by the audit director.

South West Yorkshire Partnership NHS Foundation Trust is consolidated with its charity EyUp! formerly known as South West Yorkshire Partnership Foundation Trust and Other related Charities. The Charity funds is subject to an independent examination which is not equivalent to a full audit. The Charity represents less than 0.5% of group operating income and assets employed.

We performed specified audit procedures on the Trust's subsidiary, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the charity to the group.

We have been consistent year on year when selecting our benchmarks for calculating materiality as the nature of the Trust has not changed. Our audit work was executed at levels of materiality applicable to each entity which were lower than the group.

At the group level we also tested the consolidation process.

The charity is independently reviewed by Deloitte and all work was performed by the group audit team.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

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

Responsibilities of accounting officer

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, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the Foundation Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the Foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability 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 Code of Audit Practice, 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.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

We have nothing to report in respect of these matters.

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

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

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 Code of Audit Practice.

Use of our report

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 Foundation Trust and the Boards as a body, for our audit work, for this report, or for

Paul Hewitson [FCA]
For and on behalf of Deloitte LLP
Statutory Auditor
Newcastle upon Tyne, United Kingdom

25-May-18

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2018

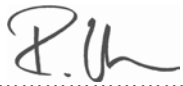
		Group		Trust	
	note	Year Ended 31 March 2018 £000	Year Ended 31 March 2017 £000	Year Ended 31 March 2018 £000	Year Ended 31 March 2017 £000
Operating income from patient care activities	5	208,032	213,967	208,032	213,967
Other operating income	5	14,848	15,940	14,760	15,851
Operating Expenses	6	(215,451)	(227,203)	(215,246)	(227,172)
Operating surplus / (deficit)		**7,429**	**2,704**	**7,546**	**2,646**
Finance costs:					
Finance income	10	66	66	65	64
PDC Dividends payable		(3,393)	(3,110)	(3,393)	(3,110)
NET FINANCE COSTS		**(3,327)**	**(3,044)**	**(3,328)**	**(3,046)**
Gains/(losses) of disposal of assets	13	425	9	425	9
SURPLUS/(DEFICIT) FOR THE YEAR		**4,527**	**(331)**	**4,643**	**(391)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	27	(1,719)	(186)	(1,719)	(186)
Revaluations	27	9,841	465	9,841	465
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**12,649**	**(52)**	**12,765**	**(112)**

The Group accounts are the consolidation of the Trust (South West Yorkshire Partnership NHS Foundation Trust) and EyUp! charity (see note 1.29 for more details).

The notes numbered 1 to 38 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2018	note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	14	231	356	231	356
Property, plant and equipment	15	123,419	110,693	123,419	110,693
Investment Property	16	160	150	160	150
Total non-current assets		**123,810**	**111,199**	**123,810**	**111,199**
Current assets					
Inventories	20	232	166	232	166
Trade and other receivables	21	8,132	8,634	8,134	8,659
Non-current assets for sale and assets in disposal groups	17	0	1,768	0	1,768
Cash and cash equivalents	22	27,108	27,053	26,559	26,373
Total current assets		**35,472**	**37,621**	**34,925**	**36,966**
Current liabilities					
Trade and other payables	23	(16,917)	(18,310)	(16,882)	(18,283)
Provisions	25	(3,377)	(4,307)	(3,377)	(4,307)
Other liabilities	23	(670)	(754)	(670)	(754)
Total current liabilities		**(20,964)**	**(23,371)**	**(20,929)**	**(23,344)**
Total assets less current liabilities		**138,318**	**125,449**	**137,806**	**124,821**
Non-current liabilities					
Provisions	25	(3,113)	(3,243)	(3,113)	(3,243)
Total assets employed		**135,205**	**122,206**	**134,693**	**121,578**
Financed by					
Taxpayers' equity					
Public Dividend Capital		44,015	43,665	44,015	43,665
Revaluation reserve	27	24,938	18,765	24,938	18,765
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		60,520	53,928	60,520	53,928
Others' equity					
Charitable fund reserves		512	628	0	0
Total taxpayers' and others' equity		**135,205**	**122,206**	**134,693**	**121,578**

The financial statements on pages 2 to 39 were approved by the Board of Directors and authorised for issue on the 22 May 2018 and signed on their behalf by:



Signed……

Rob Webster Chief Executive

Date 25 May 2018

GROUP STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	note	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**	Charitable Fund Reserve £000	**Group Total £000**
At 1 April 2017		43,665	18,765	5,220	53,928	121,578	628	122,206
Surplus for the year		0	0	0	4,779	4,779	(252)	4,527
Transfers between reserves		0	(1,320)	0	1,320	0	0	0
Impairments	12	0	(1,719)	0	0	(1,719)	0	(1,719)
Revaluations - property, plant and equipment	27	0	9,841	0	0	9,841	0	9,841
Transfer to retained earnings on disposal of assets	27	0	(629)	0	629	0	0	0
Public dividend capital received		350	0	0	0	350	0	350
Other reserve movements - charitable funds consolidation adjustment		0	0	0	(136)	(136)	136	0
Taxpayers' Equity at 31 March 2018		**44,015**	**24,938**	**5,220**	**60,520**	**134,693**	**512**	**135,205**

		Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**	Charitable Fund Reserve £000	**Group Total £000**
At 1 April 2016		43,492	19,452	5,220	53,354	121,518	568	122,086
Surplus for the year		0	0	0	(95)	(95)	(236)	(331)
Transfers between reserves		0	(582)	0	582	0	0	0
Impairments	12	0	(186)	0	0	(186)	0	(186)
Revaluations - property, plant and equipment	27	0	465	0	0	465	0	465
Transfer to retained earnings on disposal of assets	27	0	(384)	0	384	0	0	0
Public dividend capital received		173	0	0	0	173	0	173
Other reserve movements - charitable funds consolidation adjustment		0	0	0	(296)	(296)	296	0
Taxpayers' Equity at 31 March 2017		**43,665**	**18,765**	**5,220**	**53,928**	**121,578**	**628**	**122,206**

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 2017		43,665	18,765	5,220	53,928	121,578
Surplus for the year		0	0	0	4,643	4,643
Transfers between reserves		0	(1,320)	0	1,320	0
Impairments	12	0	(1,719)	0	0	(1,719)
Revaluations - property, plant and equipment	27	0	9,841	0	0	9,841
Transfer to retained earnings on disposal of assets	27	0	(629)	0	629	0
Public dividend capital received		350	0	0	0	350
Taxpayers' Equity at 31 March 2018		**44,015**	**24,938**	**5,220**	**60,520**	**134,693**

		Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Trust Total £000**
At 1 April 2016		43,492	19,452	5,220	53,354	121,517
Surplus for the year		0	0	0	(391)	(391)
Transfers between reserves		0	(582)	0	582	0
Impairments	12	0	(186)	0	0	(186)
Revaluations - property, plant and equipment	27	0	465	0	0	465
Transfer to retained earnings on disposal of assets	27	0	(384)	0	384	0
Public dividend capital received		173	0	0	0	173
Taxpayers' Equity at 31 March 2017		**43,665**	**18,765**	**5,220**	**53,928**	**121,578**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED		Group		Trust	
31 March 2018		**Year Ended 31 March 2018**	**Year Ended 31 March 2017**	**Year Ended 31 March 2018**	**Year Ended 31 March 2017**
	note	**£000**	**£000**	**£000**	**£000**
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		7,429	2,704	7,546	2,646
Operating surplus/(deficit)		**7,429**	**2,704**	**7,546**	**2,646**
Non-cash income and expense:					
Depreciation and amortisation	6	5,853	7,010	5,853	7,010
Net Impairments	6	(613)	3,678	(613)	3,678
Income recognised in respect of capital donations (cash and non-cash)		0	(6)	0	(6)
(Increase)/Decrease in Trade and Other Receivables	21	516	(1,547)	539	(1,569)
(Increase)/Decrease in Inventories	20	(66)	24	(66)	24
Increase/(Decrease) in Trade and Other Payables	23	(1,355)	(1,372)	(1,355)	(1,372)
Increase/(Decrease) in Other Liabilities	23	(84)	(35)	(84)	(35)
Increase/(Decrease) in Provisions	25	(1,060)	(2,467)	(1,060)	(2,467)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		8	12	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**10,628**	**8,001**	**10,760**	**7,909**
Cash flows from investing activities					
Interest received	10	65	64	65	64
Purchase of intangible assets	14	(19)	(26)	(19)	(26)
Purchase of Property, Plant and Equipment		(10,019)	(10,053)	(10,019)	(10,053)
Sale of property, plant and equipment and Investment Property		2,486	4,299	2,486	4,299
NHS Charitable Funds - net cash flows from investing activities		1	2	0	0
Net cash generated from/(used in) investing activities		**(7,486)**	**(5,714)**	**(7,487)**	**(5,716)**
Cash flows from financing activities					
Public dividend capital received		350	173	350	173
PDC Dividend paid		(3,437)	(3,100)	(3,437)	(3,100)
Net cash generated from/(used in) financing activities		**(3,087)**	**(2,927)**	**(3,087)**	**(2,927)**
Increase/(decrease) in cash and cash equivalents		**55**	**(640)**	**186**	**(734)**
Cash and Cash equivalents at 1 April		27,053	27,693	26,373	27,107
Cash and Cash equivalents at 31 March		**27,108**	**27,053**	**26,559**	**26,373**

Notes to the Accounts - 1. Accounting Policies

1 Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18 issued by the Department of Health and Social Care. 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 redundancy provision is based on detailed working papers and review as linked to the Trust Annual Plan and Cost Improvement Programme (CIP) and the impact of decommissioning intentions by commissioners.

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 2017 and as a result the revaluation was recognised in these accounts. This has been reviewed as at 31st March 2018 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 2017 / 2018 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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; and
- Specialised buildings – depreciated replacement cost or Modern Equivalent Asset (MEA).

The Trust has obtained the valuation for specialised assets based on the optimised MEA assumption as suggested in IAS 16 (Property, Plant and Equipment). In practical terms, this means assessing if:

- the location of the services could be moved to a more cost effective locality;
- the building layout is inefficient, what would the floor space be in order to deliver the same services; and
- the building footprint reduced, could the land area reduce accordingly.

During 2017 / 2018 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 2017 .

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 DHSC GAM, 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;
- 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 £5,000.

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

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

The Trust has 1 donated asset, this was a piece of equipment purchased by the Trust charity for a ward in 2016 / 2017.

1.12 Revenue government and other 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 0.10% in real terms for voluntary early retirement and injury benefit.

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

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution 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 NHS Resolution on behalf of the Trust is disclosed in the notes to the accounts (Note 25) 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 Resolution 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 2017 / 2018.

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 26.2)

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 which 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 22 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 and Social Care (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 taxpayers' 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.

1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.28 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 36 to the accounts.

1.29 Consolidation

NHS Charitable Fund

The NHS Foundation Trust is the corporate trustee to EyUp!. (previous name of 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)

1.30 Accounting standards and amendments issued but not yet adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury Financial Reporting Manual adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury adoption.

IFRS 9 Financial Instruments - effective 2018 / 2019
IFRS 15 Revenue from contracts with customers - effective 2018 / 2019
IFRS 16 Leases - effective 2019 / 2020
IFRS 17 Insurance Contracts - effective 2021 / 2022
IFRIC 22 Foreign Currency Transactions and Advance Consideration - effective 2018 / 2019
IFRIC 23 Uncertainty over Income Tax Treatments - effective 2019 / 2020

It is expected that IRFS 9 will not have an impact on the Trust.

IFRS 15 will require the Trust to review its contracts, so as to identify any contractual performance obligations to ensure that the timing of recognition of this revenue is when the obligations are satisfied. The Trust will be assessing all its contracts in due course.

IFRS 16 removes the distinction between operating and finance leases this means that the current operating leases shown in note 9.1 which are currently off balance sheet will be shown in the Trust Balance Sheet.

The impact of all the standards are still being assessed.

1.31 Going Concern

These accounts are prepared on a going concern basis (Note 38). Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. This was confirmed by the Trust Board in April 2018.

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 2018 Total £000**	**Year Ended 31 March 2017 Total £000**
NHS England	24,874	24,757
Clinical commissioning groups	166,735	170,290
NHS Foundation Trusts	509	381
NHS Trusts	1,202	0
Local Authorities	8,349	14,388
Department of Health and Social Care	0	0
NHS Other	0	61
Non NHS: Other	6,363	4,090
Total income from activities	**208,032**	**213,967**

	Group & Trust	
5.2 Analysis of income from activities	**Year Ended 31 March 2018 Total £000**	**Year Ended 31 March 2017 Total £000**
Cost and volume contract income - Mental Health Services	560	0
Block Contract income - Mental Health Services	155,984	158,048
Clinical income for the secondary commissioning of mandatory services	5,636	2,947
Income from CCGs & NHS England - Community Services	35,756	36,476
Income from other sources - Community Services	8,745	14,812
Other clinical income	1,351	1,684
Total income from activities	**208,032**	**213,967**

5.3 Other Operating Income	**Group Year Ended 31 March 2018 Total £000**	**Group Year Ended 31 March 2017 Total £000**	**Trust Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2017 Total £000**
Other operating income				
Research and development	195	139	195	139
Education and training	3,463	3,454	3,463	3,454
Education and training - notional income from apprenticeship fund	43	0	43	0
Received from other bodies: Donation of physical assets (non-cash)	0	0	0	6
Sustainability and Transformation Fund income	2,881	2,523	2,881	2,523
Other *	5,435	7,410	5,435	7,410
Income in respect of staff costs where accounted for on a gross basis	2,743	2,319	2,743	2,319
NHS Charitable Funds : Incoming Resources excluding investment income	88	95	0	0
Total other operating income	**14,848**	**15,940**	**14,760**	**15,851**
Total Operating Income	**222,880**	**229,907**	**222,792**	**229,818**

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 2018 Total £000**	**Group Year Ended 31 March 2017 Total £000**	**Trust Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2017 Total £000**
Estates recharges	224	364	224	364
IT recharges	122	50	122	50
Pharmacy sales	0	11	0	11
Staff contributions to employee benefit schemes	2,631	2,759	2,631	2,759
Catering	259	252	259	252
Property rentals	81	43	81	43
Other	2,118	3,931	2,118	3,931
Total	**5,435**	**7,410**	**5,435**	**7,410**

5.4 Income from activities from Commissioner Requested Services and all other services	**Group Year Ended 31 March 2018 Total £000**	**Group Year Ended 31 March 2017 Total £000**	**Trust Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2017 Total £000**
Income from Commissioner Requested Services	208,032	213,967	208,032	213,967
Income from non-Commissioner Requested Services	14,848	15,940	14,760	15,851
Total Income	**222,880**	**229,907**	**222,792**	**229,818**

5.5 Operating lease income

The Group & Trust earned no income from operating leases in 2017/18 or in 2016/17.

6 Operating Expenses

6.1 Operating Expenses	Note	Group Year Ended 31 March 2018 £000	Group Year Ended 31 March 2017 £000	Trust Year Ended 31 March 2018 £000	Trust Year Ended 31 March 2017 £000
Purchase of healthcare from NHS and DHSC bodies		251	112	251	112
Purchase of healthcare from non-NHS and non-DHSC bodies		5,640	6,255	5,640	6,255
Staff and executive directors costs		166,335	170,906	166,287	170,906
Non-executive directors		145	147	145	147
Supplies and services - clinical (excluding drug costs)		4,239	4,370	4,239	4,370
Supplies and services - general		3,246	3,776	3,246	3,776
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		3,720	3,713	3,720	3,713
Consultancy		265	621	265	621
Establishment		7,922	6,092	7,922	6,068
Premises - Business rates payable to Local Authorities		987	1,079	987	1,079
Premises - other		7,483	8,530	7,483	8,530
Transport (Business travel only)		147	171	147	172
Transport (other)		321	600	321	581
Depreciation on property, plant and equipment	15	5,709	6,845	5,709	6,845
Amortisation on intangible assets	14	144	165	144	165
Net Impairments of property, plant and equipment	12	(613)	3,678	(613)	3,678
Increase / (decrease) in provision for impairment of receivables	21.2	23	6	23	6
Change in provisions discount rate	25	18	150	18	150
Audit services- statutory audit		62	62	62	62
Other auditor remuneration	6.2	0	21	0	21
Audit services - charitable fund accounts		1	1	0	0
Internal audit - non-staff		98	124	98	124
Clinical negligence - amounts payable to NHS Resolution (premium)	25	476	340	476	340
Legal fees		219	187	219	187
Insurance		251	287	251	287
Education and training - non-staff		752	676	752	676
Education and training - notional expenditure funded from apprenticeship fund		43	0	43	
Operating lease expenditure (net)	9.1	6,474	7,692	6,474	7,692
Early retirements - non-staff		(22)	35	(22)	35
Redundancy costs - non staff costs		60	94	60	94
Car parking and security		24	17	24	17
Hospitality		35	79	35	79
Other losses and special payments - non-staff	36	51	56	51	56
Other services (e.g. external payroll)		3	1	3	1
Other NHS charitable fund resources expended		292	281	0	
Other		650	34	786	327
Total Operating Expenses		**215,451**	**227,203**	**215,246**	**227,172**

6.2 Other Audit Remuneration	Group & Trust	
	Year Ended 31 March 2018	Year Ended 31 March 2017
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	0	21
Total	**0**	**21**

6.3 Auditor Liability

The auditors liability for 2017/18 and 2016/17 is limited to £1m.

6.4 The late payment of commercial debts (interest) Act 1998

The Group & Trust has no late payments of commercial debts in 2017/18 or in 2016/17.

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 2018			Trust Year Ended 31 March 2018		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	132,441	119,501	12,940	132,441	119,501	12,940
Social Security Costs	11,559	10,530	1,029	11,559	10,530	1,029
Apprenticeship levy	619	565	54	619	565	54
Pension costs - defined contribution plans employers contributions to NHS Pensions	16,093	15,320	773	16,093	15,320	773
Termination benefits	0	0	0	0	0	0
Agency/contract staff	5,824	0	5,824	5,824	0	5,824
NHS charitable funds staff	48	48	0	0	0	0
Employee benefits expense	**166,584**	**145,964**	**20,620**	**166,536**	**145,916**	**20,620**
Of which are capitalised as part of assets	249	249	0	249	249	0
Total Employee benefits excl. capitalised costs	**166,335**	**145,715**	**20,620**	**166,287**	**145,667**	**20,620**

	Group Year Ended 31 March 2017			Trust Year Ended 31 March 2017		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	133,512	119,604	13,908	133,563	119,655	13,908
Social Security Costs	11,596	10,667	929	11,596	10,667	929
Pension costs - defined contribution plans employers contributions to NHS Pensions	16,181	15,424	757	16,181	15,424	757
Termination benefits	0	0	0	0	0	0
Agency/contract staff	9,819	0	9,819	9,819	0	9,819
NHS charitable funds staff	51	51	0	0	0	0
Employee benefits expense	**171,159**	**145,746**	**25,413**	**171,159**	**145,746**	**25,413**
Of which are capitalised as part of assets	253	253	0	253	253	0
Total Employee benefits excl. capitalised costs	**170,906**	**145,493**	**25,413**	**170,906**	**145,493**	**25,413**

As included within the salaries and wages information above, the Trust made payments in 2017/18 and 2016/17 of greater than £100k to the following staff groups:

	Year Ended 31 March 2018	Year Ended 31 March 2017
Medical Consultant	53	60
Middle Grade Doctor	12	8
Director / Chief Executive	6	6
Clinical Psychologist	1	0
Total	**72**	**74**

7. Employee costs and numbers (continued)

7.2 Average number of people employed

	Group			Trust		
	Year Ended 31 March 2018			Year Ended 31 March 2018		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	189	170	19	189	170	19
Administration and estates	1,066	1,031	35	1,064	1,029	35
Healthcare assistants and other support staff	772	635	137	772	635	137
Nursing, midwifery and health visiting staff	1,315	1,246	69	1,315	1,246	69
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	754	735	19	754	735	19
Social care staff	28	28	0	28	28	0
Other	0	0	0	0	0	0
Total	**4,124**	**3,845**	**279**	**4,122**	**3,843**	**279**
Of which are engaged on capital projects	**4**	**4**	**0**	**4**	**4**	**0**

	Group			Trust		
	Year Ended 31 March 2017			Year Ended 31 March 2017		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	194	167	27	194	167	27
Administration and estates	1,124	1,083	41	1,126	1,085	41
Healthcare assistants and other support staff	795	669	126	795	669	126
Nursing, midwifery and health visiting staff	1,376	1,286	90	1,376	1,286	90
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	696	687	9	696	687	9
Social care staff	38	38	0	38	38	0
Other	0	0	0	0	0	0
Total	**4,223**	**3,930**	**293**	**4,225**	**3,932**	**293**
Of which are engaged on capital projects	**4**	**4**	**0**	**4**	**4**	**0**

Unit of measure is whole time equivalent (WTE).

7.3 Staff sickness absence

	Group & Trust	
	Year Ended 31 March 2018	Year Ended 31 March 2017
	Number	Number
Total days lost	45,920	44,714
Total staff years	3,902	3,997
Average working days lost	11.8	11.2

This information although based on Trust data is supplied for the accounts by the Department of Health and Social
The source for disclosure of this information is from the central electronic payroll records held at the Department of Health and Social Care. The figures quoted are based on a reference period January to December, i.e. for 2017/18 January 2017 - December 2017.

7.4 Early retirements due to ill health

During the year there were 7 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health (7 during 2016/17). The estimated additional pension liabilities of these ill-health retirements is £600k (2016/17 £401k). 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

28 compulsory 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 2018

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	39	5	25	**10**	**64**
£10,001 - £25,000	14	228	2	42	**16**	**270**
£25,001 - £50,000	5	175	0	0	**5**	**175**
£50,001 - £100,000	1	90	0	0	**1**	**90**
£100,001 - £150,000	2	275	0	0	**2**	**275**
£150,001 - £200,000	1	160	0	0	**1**	**160**
Total number of exit packages by type	**28**	**967**	**7**	**67**	**35**	**1,034**

Group & Trust

31 March 2017

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	12	77	0	0	**12**	**77**
£10,001 - £25,000	18	305	0	0	**18**	**305**
£25,001 - £50,000	17	594	0	0	**17**	**594**
£50,001 - £100,000	11	837	0	0	**11**	**837**
£100,001 - £150,000	1	132	0	0	**1**	**132**
£150,001 - £200,000	2	320	0	0	**2**	**320**
Total number of exit packages by type	**61**	**2,265**	**0**	**0**	**61**	**2,265**

Exit Packages: other (non-compulsory) departure payments	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	31 March 2018	31 March 2018	31 March 2017	31 March 2017
	Number	£'000	Number	£'000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	3	34	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-Contractual payments requiring HMT approval	0	0	0	0
Total	**3**	**34**	**0**	**0**
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 determined 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 2018, is based on the valuation data as at 31 March 2017, updated to 31 March 2018 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 allow for the level of contribution rates to be changed 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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.

National Employment Savings Trust (NEST)

In 2017/18 the Trust continued its participation of the National Employment Savings Trust (NEST) which is a defined contribution workplace pension scheme. The scheme is in use for a small number of staff as an alternative to the NHS Pension Scheme. Employer and employee contributions for the year totalled £30k (2016/17 £28k). NEST is a scheme set up by government to enable employers to meet their pension duties and is free for employers to use. Employee and employer contribution rates are a combined minimum of 5% (with a minimum 2% being contributed by the Trust) and from October 2018 the combined contribution rate will be 8% (with a minimum 3% being contributed by the Trust).

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 a 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 31 lease properties, all with different Landlords. The rental periods range from 1 to 19 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 2018 £000**	**Year Ended 31 March 2017 £000**
Minimum lease payments	6,474	7,692
	6,474	**7,692**

Future minimum lease payments due	**Year Ended 31 March 2018 £000**	**Year Ended 31 March 2017 £000**
Payable:		
Not later than one year	5,109	4,926
Between one and five years	13,573	13,324
After five years	22,325	21,595
Total	**41,007**	**39,845**

10. Finance Income	Group Year Ended 31 March 2018 £000	Group Year Ended 31 March 2017 £000	Trust Year Ended 31 March 2018 £000	Trust Year Ended 31 March 2017 £000
Interest on loans and receivables	65	64	65	64
NHS Charitable funds: investment income	1	2	0	0
Total	**66**	**66**	**65**	**64**

The Group & Trust has no interest on impaired financial assets included in finance income in 2017/18 or in 2016/17.

11. Finance Costs - interest expense

The Group & Trust incurred no finance costs in 2017/18 or in 2016/17.

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

	Group & Trust					
	31 March 2018			31 March 2017		
	Net Impairment £000	Impairments £000	Reversals £000	Net Impairment £000	Impairments £000	Reversals £000
Impairments charged to operating surplus / deficit:						
Changes in market price	(613)	2,020	(2,633)	3,678	4,464	(786)
Total Impairments charged to operating surplus / deficit	**(613)**	**2,020**	**(2,633)**	**3,678**	**4,464**	**(786)**
Loss as a result of catastrophe	0	0	0	725	725	0
Other	0	0	0	471	471	0
Changes in market price	1,719	1,719	0	(1,010)	867	**(1,877)**
Total Impairments charged to the revaluation reserve	**1,719**	**1,719**	**0**	**186**	**2,063**	**(1,877)**
Total Net Impairments	**1,106**	**3,739**	**(2,633)**	**3,864**	**6,527**	**(2,663)**

In 2016/17 there was a fire in one unit which led to an impairment charge for the ward.

13. Gains/losses on disposal/derecognition of assets

	Group & Trust	
	Year Ended 31 March 2018 £000	Year Ended 31 March 2017 £000
Gains on disposal/derecognition of land and buildings	88	19
Gains on disposal/derecognition of investment properties	0	0
Gain on disposal/derecognition of assets held for sale	347	31
Losses on disposal/derecognition of land and buildings	0	0
Losses on disposal/derecognition of other property, plant and equip	(20)	(41)
Losses on disposal/derecognition of investment properties	0	0
Total gains/(losses) on disposal of assets	**415**	**9**
Fair value gains/(losses) on investment properties	10	0
Total other gains/(losses)	**425**	**9**

14 Intangible assets

14.1 Intangible assets 2017/18

	Group & Trust	
	Total	Software licences (purchased)
	£000	£000
Gross cost at 1st April 2017	**1,920**	1,920
Additions - purchased	**19**	19
Disposals / derecognition	**0**	0
Gross Cost at 31 March 2018	**1,939**	**1,939**
Amortisation at 1st April 2017	**1,564**	1,564
Provided during the year	**144**	144
Disposals / derecognition	**0**	0
Amortisation at 31 March 2018	**1,708**	**1,708**
Net book value		
NBV - Purchased at 31 March 2018	**231**	231
NBV total at 31 March 2018	**231**	**231**

14.2 Intangible assets 2016/17

	Group & Trust	
	Total	Software licences (purchased)
	£000	£000
Gross cost at 1st April 2016	**1,989**	1,989
Additions - purchased	**26**	26
Disposals / derecognition	**(95)**	(95)
Gross Cost at 31 March 2017	**1,920**	**1,920**
Amortisation at 1st April 2016	**1,464**	1,464
Provided during the year	**165**	165
Disposals / derecognition	**(65)**	(65)
Amortisation at 31 March 2017	**1,564**	**1,564**
Net book value		
NBV - Purchased at 31 March 2017	**356**	356
NBV total at 31 March 2017	**356**	**356**

14.3 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.

15. Property, plant and equipment

15.1 Property, plant and equipment 31 March 2018

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 2017	**130,682**	16,908	94,837	5,685	4,929	822	5,665	1,836
Additions - purchased	**10,003**	0	1,242	7,042	108	0	1,611	0
Impairments charged to the revaluation reserve (note 12)	**(1,820)**	0	(1,820)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**0**	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	**0**	0	0	0	0	0	0	0
Reclassifications	**0**	0	8,626	(8,626)	0	0	0	0
Revaluations	**(4,706)**	252	(4,958)	0	0	0	0	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**(532)**	(160)	(145)	0	(47)	(160)	(4)	(16)
Cost or Valuation at 31 March 2018	**133,627**	**17,000**	**97,782**	**4,101**	**4,990**	**662**	**7,272**	**1,820**
Accumulated depreciation at 1st April 2017	**19,989**	70	11,690	0	3,542	727	3,069	891
Provided during the year	**5,709**	0	4,234	0	308	46	968	153
Impairments charged to operating expenses(note 12)	**2,020**	0	2,020	0	0	0	0	0
Impairments charged to the revaluation reserve	**(101)**	0	(101)	0	0	0	0	0
Reversal of impairments credited to operating expenses (note :	**(2,633)**	(5)	(2,628)	0	0	0	0	0
Revaluations	**(14,547)**	0	(14,547)	0	0	0	0	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**(229)**	0	(20)	0	(30)	(160)	(3)	(16)
Accumulated depreciation at 31 March 2018	**10,208**	**65**	**648**	**0**	**3,820**	**613**	**4,034**	**1,028**
Net book value								
Net book value at 31 March 2018								
NBV - Owned at 31 March 2018	**123,419**	16,935	97,134	4,101	1,170	49	3,238	792
NBV - Donated at 31 March 2018	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2018	**123,419**	**16,935**	**97,134**	**4,101**	**1,170**	**49**	**3,238**	**792**

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.

15.2 Property, plant and equipment 31 March 2017

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 2016	**128,634**	18,169	95,807	2,481	5,073	822	4,446	1,836
Additions - purchased	**10,426**	0	2,100	7,239	264	0	823	0
Additions - donations of physical assets (non-cash)	**6**	0	0	0	6	0	0	0
Impairments charged to the revaluation reserve (note 12)	**(2,063)**	0	(2,063)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**413**	413	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	**1,877**	0	1,877	0	0	0	0	0
Reclassifications	**0**	0	4,035	(4,035)	(396)	0	396	0
Revaluations	**(5,439)**	465	(5,904)	0	0	0	0	0
Reclassified as held for sale	**(2,924)**	(2,089)	(835)	0	0	0	0	0
Disposals	**(248)**	(50)	(180)	0	(18)	0	0	0
Cost or Valuation at 31 March 2017	**130,682**	**16,908**	**94,837**	**5,685**	**4,929**	**822**	**5,665**	**1,836**
Accumulated depreciation at 1st April 2016	**15,174**	70	7,962	0	3,367	677	2,371	727
Provided during the year	**6,845**	0	5,751	0	342	50	538	164
Impairments charged to operating expenses(note 12)	**4,464**	0	4,464	0	0	0	0	0
Reversal of impairments credited to operating income (note 12	**(373)**	0	(373)	0	0	0	0	0
Revaluations	**(5,904)**	0	(5,904)	0	0	0	0	0
Reclassifications	**0**	0	0	0	(160)	0	160	0
Reclassified as held for sale	**(100)**	0	(100)	0	0	0	0	0
Disposals	**(117)**	0	(110)	0	(7)	0	0	0
Accumulated depreciation at 31 March 2017	**19,989**	**70**	**11,690**	**0**	**3,542**	**727**	**3,069**	**891**
Net book value								
Net book value at 31 March 2017								
NBV - Owned at 31 March 2017	**110,693**	16,838	83,147	5,685	1,387	95	2,596	0 945
NBV - Donated at 31 March 2017	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2017	**110,693**	**16,838**	**83,147**	**5,685**	**1,387**	**95**	**2,596**	**945**

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.

15.3 Economic Lives of Property, Plant and Equipment

	Group & Trust	
	Min Life Years	**Max Life Years**
Land		
Buildings excluding dwellings	0	90
Plant & Machinery	0	10
Transport Equipment	0	3
Information Technology	0	5
Furniture & Fittings	0	8

15.4 Finance Leases

The Group & Trust hold no finance lease assets.

16 Investments

16.1 Investments - Carrying Value

	Group & Trust	
	Property*	Property*
	31 March 2018	31 March 2017
	£000	£000
At Carrying Value		
Balance at Beginning of Period	150	150
Fair value gains (taken to I&E)	10	0
Disposals	0	0
Balance at End of Period	**160**	**150**

* 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.

16.2 Investment Property expenses

The Group & Trust incurred £0k on investment property expenses in 2017/18 (£0k in 2016/17).

16.3 Investments in subsidiaries

The Trust is the Corporate Trustee for the NHS Charity, EyUp!,(previous name South West Yorkshire Partnership Foundation Trust and Other Related Charities) registered charity number 1055931 by the The Charity operates for the benefit of the Service Users of the Trust. The Charity is fully consolidated into the Trust accounts.

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 2017/18.

Summary Statement of Financial Activities

	31 March 2018	31 March 2017
	£000	£000
Total Incoming Resources	225	400
Staff Costs	(48)	(51)
Resources expended with bodies outside the NHS	(293)	(288)
Net movement in funds	**(116)**	**61**

Summary Statement of Financial Position	31 March 2018	31 March 2017
	£000	£000
Cash and cash equivalents	549	680
Trade and other receivables	0	0
Trade and other payables	(37)	(52)
Net Assets	**512**	**628**
Other restricted income funds	363	433
Unrestricted income funds	149	195
Total Charitable Funds	**512**	**628**

Restricted income funds include the linked charities of Creative Minds and the Mental Health Museum. The majority of the restricted funds relate to Creative Minds (£348k).

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

17.1 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 2017	**1,768**	**1,713**	**55**
Plus assets classified as available for sale in the year	0	0	0
Less assets sold in year	(1,768)	(1,713)	(55)
NBV of non-current assets for sale at 31 March 2018	**0**	**0**	**0**

	Group & Trust		
	Total	**PPE: Land**	**PPE: Buildings**
	£000	**£000**	**£000**
NBV of non-current assets for sale at 1 April 2016	**299**	**130**	**169**
Plus assets classified as available for sale in the year	2,824	2,089	735
Less assets sold in year	(1,355)	(506)	(849)
NBV of non-current assets for sale at 31 March 2017	**1,768**	**1,713**	**55**

The assets are held at the lower of costs to sell rather than fair value in use, with the expected recoverable amount being higher value stated in the accounts.

17.2 Liabilities in disposal groups

The Group & Trust has no liabilities in disposal groups in 2017/18 or in 2016/17.

18. Other assets

The Group & Trust has no other assets in 2017/18 or in 2016/17.

19. Other Financial Assets

The Group & Trust has no other financial assets in 2017/18 or in 2016/17.

20. Inventories

20.1. Inventory Movements

	Group & Trust		
	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2017	**166**	**82**	**84**
Additions	3,442	3,072	370
Inventories recognised in expenses	(3,376)	(2,987)	(389)
Carrying Value at 31 March 2018	**232**	**167**	**65**

	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2016	**190**	**69**	**121**
Additions	3,475	3,149	326
Inventories recognised in expenses	(3,499)	(3,136)	(363)
Carrying Value at 31 March 2017	**166**	**82**	**84**

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.

21. Trade and other receivables

21.1 Trade and other receivables	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Current				
Trade receivables	3,195	4,104	3,195	4,104
Accrued income	3,704	3,244	3,704	3,244
Provision for impaired receivables	(121)	(98)	(121)	(98)
Prepayments	1,171	1,015	1,171	1,015
PDC dividend receivable	14	0	14	0
VAT receivable	159	380	159	380
Other receivables	10	(11)	12	14
NHS Charitable funds: Trade and other receivables	0	0	0	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**8,132**	**8,634**	**8,134**	**8,659**
Of which receivable from NHS and DHSC group bodies:				
Current	4,157	3,958	4,157	3,958

The Group & Trust have no non current trade and other receivables as at 31 March 2018 (£0 (zero) as at 31 March 2017).

21.2 Provision for impairment of receivables	Group & Trust 31 March 2018 £000	Group & Trust 31 March 2017 £000
Balance at start of period	98	92
Increase in provision	60	48
Amounts utilised	0	0
Unused amounts reversed	(37)	(42)
Balance at 31 March	**121**	**98**

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.

21.3 Analysis of impaired receivables	Group & Trust 31 March 2018 £000	Group & Trust 31 March 2017 £000
Ageing of impaired receivables		
0 - 30 days	8	21
30-60 Days	1	5
60-90 days	0	1
90- 180 days	38	15
over 180 days	74	56
Total	**121**	**98**

	Group & Trust 31 March 2018 £000	Group & Trust 31 March 2017 £000
Ageing of non-impaired receivables past their due date		
0 - 30 days	1,144	770
30-60 Days	399	207
60-90 days	42	101
90- 180 days	173	146
over 180 days	99	149
Total	**1,857**	**1,373**

21.4 Finance lease receivables

The Group & Trust has no finance lease receivables.

22. Cash and cash equivalents	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Balance at 1st April	**27,053**	**27,693**	**26,373**	**27,107**
Net change in year	55	(640)	186	(734)
Balance at 31 March	**27,108**	**27,053**	**26,559**	**26,373**
Broken down into:				
Cash at commercial banks and in hand	632	823	83	143
Cash with the Government Banking Service	26,476	26,230	26,476	26,230
Cash and cash equivalents as in statement of financial position	**27,108**	**27,053**	**26,559**	**26,373**
Cash and cash equivalents as in statement of cash flows	**27,108**	**27,053**	**26,559**	**26,373**

Third party assets (Patient Monies) held by the Trust

	Group & Trust 31 March 2018 £000	Group & Trust 31 March 2017 £000
Bank balances	257	176
Monies on deposit	88	93
Total third party assets	**345**	**269**

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

23. Trade and other payables

23.1 Trade and other payables	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Current				
Trade payables	4,093	4,916	4,093	4,916
Capital payables (including capital accruals)	1,142	1,158	1,142	1,158
Accruals	5,798	6,159	5,798	6,159
Social Security costs	2,235	2,245	2,235	2,245
Other taxes payable	1,392	1,367	1,392	1,367
Other payables	2,222	2,408	2,222	2,408
PDC dividend payable	0	30	0	30
NHS Charitable funds: Trade and other payables	35	27	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**16,917**	**18,310**	**16,882**	**18,283**
Of which payable to NHS and DHSC group bodies				
Current	1,655	2,971	1,655	2,971

The Group & Trust had no non-current trade and other payables as at 31 March 2018 (£0 (zero) as at 31 March 2017).

23.2 Better Payment Practice Code

	Group & Trust	
Better Payment Practice Code - measure of compliance	**31 March 2018 Number**	**31 March 2018 £000**
Total Non-NHS trade invoices paid in the year	35,479	89,007
Total Non NHS trade invoices paid within target	34,627	86,974
Percentage of Non-NHS trade invoices paid within target	**98%**	**98%**
Total NHS trade invoices paid in the year	837	15,251
Total NHS trade invoices paid within target	776	13,577
Percentage of NHS trade invoices paid within target	**93%**	**89%**
	31 March 2017 Number	**31 March 2017 £000**
Total Non-NHS trade invoices paid in the year	37,235	97,271
Total Non NHS trade invoices paid within target	35,537	93,256
Percentage of Non-NHS trade invoices paid within target	**95%**	**96%**
Total NHS trade invoices paid in the year	760	11,968
Total NHS trade invoices paid within target	682	10,810
Percentage of NHS trade invoices paid within target	**90%**	**90%**

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.

23.3 Early retirements detail included in NHS payables

The Group & Trust had no early retirement costs included in payables as at 31 March 2018 (£0 (zero) as at 31 March 2017).

23.4 Other liabilities

	Group & Trust	
	31 March 2018 £000	**31 March 2017 £000**
Current		
Deferred Income	670	754
TOTAL OTHER CURRENT LIABILITIES	**670**	**754**
Non-current		
Deferred Income	0	0
TOTAL OTHER NON CURRENT LIABILITIES	**0**	**0**

23.5 Other Financial Liabilities

The Group & Trust had no other financial liabilities as at 31 March 2018 (£0 (zero) as at 31 March 2017).

24. Borrowings

The Group & Trust had no borrowings as at 31 March 2018 (£0 (zero) as at 31 March 2017).

25. Provisions

	Group & Trust Current		Group & Trust Non-current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Pensions relating to other staff	55	59	495	574
Legal claims	45	29	689	706
Redundancy	3,218	4,161	490	490
Other				
Injury Benefit	59	58	939	973
Other	0	0	500	500
Total	**3,377**	**4,307**	**3,113**	**3,243**

	Group & Trust				
	Total	Pensions relating to other staff	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000
At 1 April 2017	7,550	633	735	4,651	1,531
Change in the discount rate	18	5	0	0	13
Arising during the year	3,355	27	342	2,973	13
Utilised during the year (accruals)	(29)	(14)	0	0	(15)
Utilised during the year (cash)	(1,166)	(43)	(77)	(1,002)	(44)
Reversed unused	(3,238)	(58)	(266)	(2,914)	0
At 31 March 2018	**6,490**	**550**	**734**	**3,708**	**1,498**
Expected timing of cash flows:					
Not later than one year;	3,377	55	45	3,218	59
Later than one year and not later than five years;	2,131	217	689	490	735
Later than five years (see note 31.3).	982	278	0	0	704
Total	**6,490**	**550**	**734**	**3,708**	**1,498**

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 £3.7m, relates to approximately 62 posts during 2018/2019 and a further 13 redundancies during 2019/2020. These are estimates based upon the Trust Annual Plan and Cost Improvement Programme and commissioning intentions of commissioners.

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.

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.

£2,741K is included in the provisions of the NHS Resolution at 31 March 2018 (£4,682k at 31 March 2017) in respect of clinical negligence liabilities of the NHS Trust.

26. Contingencies

26.1 Contingent liabilities

The Group & Trust had no contingent liabilities as at 31 March 2018 (none as at 31 March 2017).

26.2 Contingent assets

The Group & Trust had 1 contingent asset as at 31 March 2018 (1 as at 31 March 2017).

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.

27. Revaluation reserve

	Group & Trust	
	Total Revaluation Reserve £000	**Revaluation Reserve - property, plant and equipment £000**
As at 1 April 2017	**18,765**	**18,765**
Impairments	(1,719)	(1,719)
Revaluations	9,841	9,841
Transfers to other reserves	(1,320)	(1,320)
Asset disposals	(629)	(629)
Revaluation reserve at 31 March 2018	**24,938**	**24,938**
	£000	**£000**
As at 1 April 2016	**19,452**	**19,452**
Impairments	(186)	(186)
Revaluations	465	465
Transfers to other reserves	(582)	(582)
Asset disposals	(384)	(384)
Revaluation reserve at 31 March 2017	**18,765**	**18,765**

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.

28. Finance lease obligations

The Group & Trust had no finance lease obligations.

29. Finance lease commitments

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

30. Capital commitments

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

	Group & Trust	
	31 March 2018 £000	**31 March 2017 £000**
Property, plant and equipment	5,249	10,726
Intangible assets	0	0
Total	**5,249**	**10,726**

These capital commitments relate to on-going developments for the non-secure unit at the Fieldhead site with the main Trust Contractor. Work commenced in July 2016 and is currently expected to complete in April 2019.

31. Financial Instruments

31.1 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) - with NHS and DH bodies	**4,138**	4,138	**4,138**	4,138
Trade and other receivables (excluding non-financial assets) - with other bodies	**2,652**	2,652	**2,652**	2,652
Cash and cash equivalents	**26,559**	26,559	**26,559**	26,559
NHS Charitable funds: financial assets	**549**	549	**0**	0
Total at 31 March 2018	**33,898**	**33,898**	**33,349**	**33,349**
Trade and other receivables (excluding non-financial assets) - with NHS and DH bodies	**3,958**	3,958	**3,958**	3,958
Trade and other receivables (excluding non-financial assets) - with other bodies	**3,281**	3,281	**3,281**	3,281
Cash and cash equivalents	**26,373**	26,373	**26,373**	26,373
NHS Charitable funds: financial assets	**680**	680	**0**	0
Total at 31 March 2017	**34,292**	**34,292**	**33,612**	**33,612**

There is no difference between carrying amount and fair value

31.2 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 liabilities) - with NHS and DH bodies	**1,655**	1,655	**1,655**	1,655
Trade and other payables (excluding non-financial liabilities) - with other bodies	**9,485**	9,485	**9,485**	9,485
Provisions under contract	**6,490**	6,490	**6,490**	6,490
NHS Charitable funds: financial liabilities	**0**	0	**0**	0
Total at 31 March 2018	**17,630**	**17,630**	**17,630**	**17,630**
Trade and other payables (excluding non-financial liabilities) - with NHS and DH bodies	**7,953**	7,953	**7,953**	7,953
Trade and other payables (excluding non-financial liabilities) - with other bodies	**6,688**	6,688	**6,688**	6,688
Provisions under contract	**7,550**	7,550	**7,550**	7,550
NHS Charitable funds: financial liabilities	**27**	27	**0**	0
Total at 31 March 2017	**22,218**	**22,218**	**22,191**	**22,191**

31.3 Maturity of Financial liabilities

	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
In one year or less	14,517	19,029	14,517	19,002
In more than one year but not more than two years	648	625	648	625
In more than two years but not more than five years	1,483	982	1,483	982
In more than five years (see note 25)	982	1,582	982	1,582
Total	**17,630**	**22,218**	**17,630**	**22,191**

32. 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 2018 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 groups, 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.

33. Events after the reporting period

The Group & Trust has no events after the reporting period.

34. Private Finance Initiative contracts

The Group & Trust has no Private Finance Initiative Contracts.

35. 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.

Rob Webster, Chief Executive. Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England), Visiting Professor, Leeds Beckett University, Honorary Fellow, Queen's Nursing Institute, Honorary Fellow, Royal College of General Practitioners, Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Sustainability and Transformation Plan) and Member of Bercow Review Panel, Royal College of Speech and Language Therapists (RCSLT)

Angela Monaghan, Chair of the Trust. Spouse is Strategic Director at Bradford Metropolitan District Council and Director of the National Association for Neighbourhood Management.

Laurence Campbell, Non Executive Director. Director, Trustee and Treasurer, Kirklees Citizen's Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council.

Rachel Court, Non Executive Director. Director and Chair, Leek United Building Society, Director, Leek United Financial Services Ltd, Director, Invesco Perpetual Life Ltd, Director, Invesco UK Ltd, Chair, PRISM, Governor Calderdale College, Magistrate and Chair, NHS Pension Board.

Charlotte Dyson, Non Executive Director. Independent marketing consultant, Beyondmc, 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, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards, 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.

Christopher Jones, Non Executive Director. Director and part owner, Chris Jones Consultancy Ltd and Interim Chief Executive Officer at Bradford College.

Kate Quail, Non Executive Director. Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.

Alan Davis, Director Human Resources, Organisational Development and Estates. Spouse is Managing Director, NHS North West Leadership Academy.

Carol Harris, District Director, Forensic, Specialist, Calderdale & Kirklees. Spouse Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust.

Salma Yasmeen, Director of Strategy. Board Member, PRISM charity in Bradford.

35.1 Related Party Transactions

	Group & Trust	
	Income	**Expenditure**
	£000	**£000**
Value of transactions with other related parties in 2017/18		
Department of Health	88	0
Other NHS Bodies	202,083	12,138
Other	0	0
Total	**202,171**	**12,138**

	Income	**Expenditure**
Value of transactions with other related parties in 2016/17	**£000**	**£000**
Department of Health	0	0
Other NHS Bodies	204,625	10,524
Other	0	0
Total	**204,625**	**10,524**

35.2 Related Party Balances

	Group & Trust	
	Receivables	**Payables**
	£000	**£000**
Value of transactions with other related parties in 2017/18		
Department of Health	0	0
Other NHS Bodies	4,141	1,656
Other	0	0
Total	**4,141**	**1,656**

	Receivables	**Payables**
Value of transactions with other related parties in 2016/17	**£000**	**£000**
Department of Health	0	30
Other NHS Bodies	3,957	2,941
Other	0	0
Total	**3,957**	**2,971**

36. Losses and Special Payments

	Group & Trust			
	Year Ended 31 March 2018 Total number of cases Numbers	Year Ended 31 March 2018 Total value of cases £000s	Year Ended 31 March 2017 Total number of cases Numbers	Year Ended 31 March 2017 Total value of cases £000s
Losses:				
1. Losses of cash due to:				
a. theft, fraud etc.	0	0	1	0
b. overpayment of salaries etc.	0	0	2	0
c. other causes	4	0	3	1
2. Fruitless payments and constructive losses	0	0	0	0
3. Bad debts and claims abandoned	17	10	8	15
4. Damages to buildings, property etc. (including stores losses)	0	0	0	0
Total Losses	**21**	**10**	**14**	**16**
Special Payments				
5. Compensation under legal obligation	1	1	0	0
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments				
a. loss of personal effects	38	4	50	6
d. other negligence and injury	0	0	0	0
e. other employment payments	2	32	1	34
g. other	2	4	0	0
8. Special severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0
Total Special Payments	**43**	**41**	**51**	**40**
Total Losses and Special Payments	**64**	**51**	**65**	**56**

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.

37. Gifts

The Trust has made no gifts in 2017/18 (0 (zero) in 2016/17)

38. 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.