South West Yorkshire Partnership NHS Foundation Trust

Annual Report and Accounts

for the period 1 April 2018 to 31 March 2019

With **all of us** in mind.

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS FOR THE PERIOD 1 APRIL 2018 TO 31 MARCH 2019

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 2018/19

Welcome to the Trust's annual report for the year 1 April 2018 to 31 March 2019.

On 5 July 2018 the NHS celebrated its 70th birthday. As part of the celebrations, over 1,500 of our staff – a third of our workforce – were nominated for our **NHS70 Superstars scheme**. Staff from across the organisation took the time to nominate their colleagues for going above and beyond, for being supportive in difficult times, for their kindness and compassion, or for simply making a cup of tea on a busy shift.

The range of staff nominated and the variety of reasons for putting someone forward were a heart-warming reminder of what the NHS is all about. It highlighted the fact that NHS staff don't just care for patients, they care for each other.

In March and April we welcomed the CQC's independent view of our Trust following their inspection. Our report was published in July and highlighted areas of strength and improvement, as well as areas of real challenge. 11 of our 14 core services were rated *Good* – and all of them were rated *Good* for being caring. We're proud that more than 85% of individual domains were rated *Good* or **Outstanding** (60 out of 70). Overall, we were rated *Good* for well-led, caring and effective domains, and *Requires Improvement* for safe and responsive domains. Overall, it meant that we were rated *Requires Improvement* as a Trust.

We addressed safety issues first and foremost and responded in line with our values. Whilst we were disappointed to see our overall rating go down, we thought it important not to lose sight of all the positive comments and good practice identified in the report. We've seen many examples of outstanding work throughout the year, and we celebrated just some of these achievements at our annual Excellence awards in November 2018. We had over 150 applications over the 9 categories, with the judges reporting that the quality of all entries was very high. On the day, we also celebrated learners and colleagues who have worked for the NHS for more than 25 and 40 years. Individuals and teams from across the whole Trust came together to share their work and receive recognition and thanks at what was a fantastic day of celebration.

Our Excellence awards brought our staff together to remind them of the values they share and of what they can achieve with the support of one another. Joining a staff network can help people to connect and chat with others, as well as help the Trust develop and grow. Our staff networks are a chance for our staff to meet people with similar experiences, and to contribute to the Trust's commitment to being a diverse and inclusive employer. We currently have a number of staff networks available for our staff: Black Asian Minority Ethnic (BAME), LGBT+ network, working carers' network, and disability network. All of our networks are developing and going from strength to strength, and we hope to continue this momentum into the next year.

In summer 2018, the second phase of our new adult acute mental health centre at Fieldhead Hospital in Wakefield opened, following £17m of investment in mental health services. This comprised a new entrance/visitor area, along with the full refurbishment of Priory ward. The Unity Centre has been purpose-built and treats patients from across our geographical footprint. It incorporates the Stanley male and Nostell female adult acute mental health wards, and the Walton psychiatric intensive care ward, along with a new section 136 suite. The final phase will be completed in 2019.

All three of the wards are now accredited by the Royal College of Psychiatrists. The Accreditation for Inpatient Mental Health Services (AIMS) recognises high standards of

organisation and care. In order to be given an AIMS, teams must meet national requirements from NICE and the Department of Health and Social Care.

Our investment in the Trust estate means that our staff can provide high quality care from high quality buildings. Staff and service users were involved in the design of the new Unity Centre, which is modern and relaxing with lots of open spaces and natural light. It highlights our commitment to the local area and providing patients with the best standard of care. Our service users will benefit from state-of-the-art therapeutic areas, en-suite bathrooms and vastly improved relaxation areas to help them on their journey to recovery.

We expanded the support we offer throughout 2018/19 when we welcomed new services to our Trust. This included the forensic outreach liaison service (FOLS), which supports people aged 18 years and above who have a learning disability or autism that have come into contact with the criminal justice system. Building on the success of our Barnsley service, we also recently began providing liaison and diversion services in Rotherham, Doncaster and Sheffield.

Our approach to recovery is varied. We know that creative approaches can have a big impact on people's health and wellbeing, and we're proud to offer different ways of supporting people to live well in their communities. Whether it's through our recovery college courses developed by people with personal lived experience, our funding of local creative projects through our linked charity Creative Minds, or our thought-provoking and educational Mental Health Museum, we are challenging perceptions, reducing stigma and redefining the future of mental health care.

Making plans to improve was a national focus for the NHS when a new 10-year long term plan was announced in 2018. Last summer the Prime Minister committed an extra £20.5 billion a year going into the NHS by 2023/4, and the plan shows how the extra money will be used to deliver results for patients, the public and staff. As a Trust we are pleased to see the focus on mental health, ADHD and autism, learning disabilities, community services and prevention, as investment in these is essential to meet the needs of people today and to transform health and care services for the future.

The relationships we've built with our partners are key to making improvements. People we work alongside have all sorts of agencies in their lives, and by working together to join up care we can better meet their needs. We can overcome many obstacles with strong relationships. We've played a key role in the West Yorkshire and Harrogate health and care partnership and the South Yorkshire and Bassetlaw integrated care system throughout the year, where connections between places and the bigger system have led to direct improvements. Being a part of these systems to make improvements is central to the way we work.

The wider health and social care system is under pressure to improve the quality and efficiency of services. To meet the challenges we need to think differently about how we work and how we enhance our services and communities. Evidence and research validates that volunteering adds value in a variety of ways. Our volunteers help improve the quality of care and add to the overall experience for our service users, carers, and staff. We currently have 260 volunteers across the Trust providing 34,164 hours a year helping provide additional support within our services. We have over 30 different volunteer roles across the Trust helping us better understand our diverse communities.

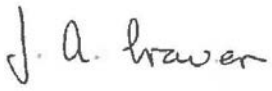
Our Annual Members' Meeting, held in September, was an opportunity to present our **annual report and accounts** and to reflect on our past performance and future plans. Governors and members from across **our** Trust were in attendance and we heard from service users and carers throughout the meeting. The meeting also gave us an opportunity

to set out our priorities for this year. Encouragingly, there's a strong alignment between the Trust's strategy and ambitions and those of the NHS as a whole.

The Trust, along with the NHS and the wider health and care sector, continues to face many challenges as it enters 2019/20. We remain committed to facing these challenges, guided as always by our mission and values, and delivering the highest possible quality of care, so that we can support people to meet their potential and live well in their community. Each month we make 34,100 mental health contacts, 6,340 community services contacts, and 3,760 health and wellbeing service contacts, plus many more. That's hundreds of thousands of lives considered, touched and changed throughout the year.

We would like to take this opportunity to thank all our staff and volunteers for another year of care, compassion and commitment.

Angela Monaghan
Chair



Jackie Craven
Lead Governor

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Section 1 – Performance Report

Section 1.1 Overview of performance

Overview

The purpose of this section is to provide a short summary of South West Yorkshire Partnership NHS Foundation Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Review of 2018/19 – Chief Executive Reflections

This year has seen many successes, achievements and overcoming of challenges. We have continued to work towards and achieved our objectives, putting our values at the heart of everything we do. Highlights include:

We delivered our mission and lived our values
We exist to help people to reach their potential and live well in their community, and we continued our passion for doing this throughout 2018/19. How we work is as important to us as what we do. Our values and how we behave really matter to us. Our values unite our staff – whatever they do and wherever they are based – and guide our efforts every day, with all of us in mind.

Over the last year, we have strengthened our values based recruitment, including for temporary staff on the staff bank. This has been augmented by a values based induction at a local and corporate level and improved values based appraisals.
The majority of our targets have been delivered across our wellbeing, learning disability, physical and mental health programmes. This means:

- 88.1% of people experiencing a first episode of psychosis were treated within two weeks of referral.
- 97.3% patients on care programme approach were followed up within seven days
- 97.7% percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper
- 94.6% service uses in crisis assessed within 4 hours
- 76.9% routine referrals assessed within 14 days of referral
- 99.5% of people were seen within 6 weeks for diagnostic procedures
- 99.4% of referrals had a waiting time for treatment of less than 18 weeks

We embraced change and tackled challenges
We operate in a changing context, with the NHS Five Year Forward View and Long Term Plan affecting every place that we work. In addition, financial pressures in our health and care systems and workforce issues mean we continuously work to prioritise delivery. Highlights include:

- Managing a challenging winter - It was an extremely demanding winter across the NHS and social care. We all pulled together to continue caring for local people. Our efforts were highlighted by NHS Providers as part of their 'Winter Watch' campaign. Our teams in Barnsley ensured that the system was one of the top performing in the

country on A&E delivery, delayed transfers of care and patients stranded in hospitals for more than 21 days.

- Maintaining system resilience during a period of uncertainty over the potential impact of Brexit and the need to change local waste contracts. We engaged fully in the contingency planning around Brexit. We quickly responded to issues in relation to waste, ensuring continuity and safe handling.
- Some of our services have seen significant changes with decommissioning, new contracts following tendering and improved models of care. This includes musculoskeletal services, improved access to psychological therapies, stroke care and services for people with a learning disability. Throughout this, we have worked to ensure that our staff are supported and transitions are well managed.
- We have continued to improve the position on adult acute mental health out of area bed placements for Wakefield, with none required since September, and our Barnsley services continue to not require them. We have sought external to help us improve and to ensure that changes identified are effective and sustainable across services, with closer working with commissioners and external experts.
- The national shortage of mental health beds for children continues to mean we have to sometimes deliver safe and effective care in other settings, such as adult wards. By working across West Yorkshire and Harrogate, we are working towards changing this, with a new 22 bedded hospital unit for children and young people being built in Leeds. Until the building is finished and opened this will continue to be a challenge at periods and our services work to ensure safety is assured at all times.
- For the third year running, we maintained high levels of flu vaccination. Over 76% of staff had their flu jab, meaning we kept more people safe from flu and retained essential funding for frontline services. This involved changes to the campaign and the way we work.

Trust Board changes – we welcomed two new non-executive directors, Sam Young and Erfana Mahmood, and thanked Rachel Court, who left the Trust in March, for her time as a non-executive director. Carol Harris became director of operations, Sean Rayner became director of provider development, and Dr Subha Thiyagesh became medical director. We operate in a changing context, with the NHS Five Year Forward View and Long Term Plan affecting every place that we work. In addition, financial pressures in our health and care systems and workforce issues mean we continuously work to prioritise delivery.

We remained focused on risk and opportunities

The reporting of incidents and near misses helps to provide essential learning on preventing risks and harm occurring. Numbers have continued to increase each year, with approximately 89% being no or low harm. Our reporting system, Datixweb, reached its 100,000th incident report on the web system – a high reporting rate with high proportion of no/low harm is indicative of a positive safety culture.

Our risk strategy continued to be strengthened with an effective system of internal governance and committee oversight. All red rated risks on the risk register and all risks outside risk tolerance are subject to additional scrutiny and control.

Alongside this, strategic risks and opportunities are reported to Board regularly to ensure there is proper oversight of them and that they are managed effectively. Our success rate in tendering programmes has been around 70%.

Our developments got us ready for tomorrow
In the current environment, we must change:

- We implemented a new clinical records system, SystmOne. This has provided us with an opportunity to look at how we use our systems to best effect, ensure it is easier for staff to use and become more efficient. This involved training nearly all mental health services staff, engaging over 250 staff in developing the system and transferring 300,000 records.
- We have continued with our investment in transforming mental health services in Wakefield. The project at Fieldhead supports our on-going commitment to improve services for local residents and included a complete redevelopment of non-secure units as well as older people's inpatient unit.
- Patients now have a free internet connection which will enable them to access a whole range of online NHS resources. This is available in places such as reception areas, waiting rooms and inpatient wards.
- We have completed rolling out Govroam wireless access across our estate and portable devices. Govroam grants people access to WiFi while working on public sector sites.
- We worked with partners across West Yorkshire and Harrogate to deliver improvements in services for people with eating disorders, children and young people's mental health services and those at risk of suicide.

We focused on becoming a better place to work
During the year, we worked with NHS Improvement to look at targeted support for recruitment and retention. This saw our turnover rate fall from 12.6% to 11.9%. This was through a range of initiatives that will need to continue.

At 5.0%, our sickness absence rate benchmarks well with other organisations of our type in our region. In the last year we have focused on supporting the health and wellbeing of staff through our #allofus campaign and targeted interventions in rapid access to physio, wellbeing advice and support and counselling.

Between October and December 2018 the **annual national NHS survey** was sent to all staff and over 1,600 people took the time and effort to give feedback on what it feels like to work for the Trust. The aim of the survey is to use this feedback to improve the working lives of staff to enable them to either support or directly provide better care for service users.

The results told us there are some areas staff believe we are good at and other areas where there is room for improvement if we are to be as good an employer as we aspire to be. This is a challenge for all our leaders and managers. There are four key areas which research has been shown to impact on quality of care that we need a strong focus on:

- Improving staff engagement – we are below average compared to similar Trusts
- Preventing bullying and harassment
- Improving the quality of appraisal
- Improving staff health and wellbeing

If we get these things right then staff and service user experience will improve

We took positive action on our finances

We know that there are service and financial pressures in both the health system and with our local government partners. At the same time, we have recently seen much needed targeted investment in new services like perinatal mental health and improving access to psychological therapies.

There has been lots of positive action during 2018/19 which has meant that we've been able to deliver, and in fact improve upon our financial target. Our deficit position, prior to Provider Sustainability Funding, was a deficit of £1.6m. By delivering our financial plan, we received access to £4.7m of national funding, meaning a surplus before the impact of asset revaluations of £3.1m. This will be used to support continued investment into our estate and technology.

This was possible because of cost improvement delivery of over £10.6m and income support from our commissioners. This has helped to ensure that the Trust had a healthy cash position throughout the year and been able to pay suppliers in a timely fashion; with 98% paid to better payment standards within 30 days.

We showcased our work and won awards

- Our flu campaign won an award for the most innovative campaign at the national Flu Fighter awards
- Our Barnsley and Wakefield health integration teams, who offer care and support to refugees and asylum seekers were recognised. Our Barnsley team were chosen by the British Institute of Human Resources as a case study for their project on access to healthcare for asylum seekers, and our Wakefield team were shortlisted for the 'Community and general practice nursing award' in the prestigious RCNi Nurse Awards.
- Our #allofus campaign was shortlisted for the Health Service Journal value awards.
- Our medical education team won a certificate of merit in the team category of the Clinical Teaching Excellence Awards.
- Our patient safety manager Helen Roberts was shortlisted in the 'Leader of the year' category in the national Unsung Hero Awards 2019
- The adult ADHD project team were nominated in the 'Psychiatric team of the year: working age adults' category at the Royal College of Psychiatrists Award 2018.
- Creative Recovery was selected as a finalist for the Tour De Yorkshire Land Art Competition.
- Our Creative Minds team were nominated in the West Riding FA awards in the outstanding contribution to disabled football category.
- Social worker Rosie Meleady was chosen as 'Social work practice educator of the year' at a national conference run by Leeds Beckett University, University of Leeds and The Open University.
- Judith Megson, team manager in our Kirklees older people's services, won the 'higher apprentice of the year' award in the Wakefield College apprentice awards. Jan Spence, manager of Yorkshire Smokefree in Calderdale was also nominated as a finalist for the award.
- Beechdale ward was recognised for reducing their violence and aggression incidents. Willow ward were also putting safety first too. Chantry Ward has received their Bronze award for 33 days without a patient fall.
- We were shortlisted in the Nursing Times Workforce Awards for our work to improve staffing levels.

- Two units in Barnsley were awarded certificates for achieving a reduction in the number of falls occurring on their wards.
- One of our Health & Wellbeing members of staff received the higher apprentice of the year
- Our Paediatric Speech and Language Therapy service received 5 stars from health watch for its service provision

Some things will need continuing focus in 2019/20
Our priorities for the coming year will mean a strong focus on:

- Joining up care in all of the places we work
- Delivering improvements in quality, reflected in improved CQC ratings
- Delivering our financial targets through greater cost control and productivity
- Making the Trust a great place to work, where everyone has a good appraisal and is engaged in the business of the organisation.

We have set **our priorities** for the year ahead, which outline what we want to achieve and how we will achieve it. 2018/19 had its highs and lows for many of us. We're committed to taking the lessons learnt, the successes celebrated and the hardships weathered in this year and continuing our efforts into 2019/20.

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, and health and wellbeing services (smoking cessation) in districts in South Yorkshire.

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** in 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 2018/19 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, and smoking cessation services in South Yorkshire. 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 and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement. Other key issues identified through the quarterly Board Investment appraisal reports and biennial 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 have implemented a new clinical record system which was co-designed with clinical staff with 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 2019/20, 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 2018/19, 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	1
% service users followed up within 7 days of discharge	95%	98.1%
% clients in settled accommodation	60%	78.2%*
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks(as at Quarter 3)	95%	82.8%
Out of area beds (days)	2,800	4,904
Improving Access to Psychological Therapies (IAPT) – proportion of people completing treatment and moving to recovery	50%	56.5%

*as at February 2019. Performance has been consistently at this level throughout the year

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 adult acute mental health out of area bed placements is explained more fully in other sections of this report on pages 21, 24 and 32, but the Trust strives to keep the use of such placements to an absolute minimum, and aims to support people in their district of residence as far as possible. Demand for beds was such that we did not achieve our target. Along with our commissioners we did engage independent expertise during the year to review our bed management and associated processes. This identified potential

improvements which are actively being implemented with the aim of reducing the number of out of area bed placements we need to make.

Improve the quality and experience of care		
KPI	**Target**	**Year-End Performance**
Friends and Family Test – Mental Health	85%	95%
Friends and Family Test - Community	98%	99%
Patient safety incidents involving moderate or severe harm or death *	-	36
Safer staff fill rates	90%	118%
Information Governance confidentiality breaches *	<8	9
% people dying in their place of choosing	-	82.6%

*monthly figure for March

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. Friends and Family Test results for Mental Health and Community services show a large number of respondents and very positive feedback.

Improve the use of resources		
KPI	**Target**	**Year-End Performance**
CQUIN achievement	£4.2m	£4.1m
Trust Surplus/(Deficit)	(£2.0m)	(£1.6m)
Agency spend	£5.3m	£6.5m
Cost Improvement Projects (CIP) delivery	£9.7m	£10.6m
Sickness absence	4.5%	5.0%
Aggression Management Training	80%	81.7%
Moving & Handling Training	80%	90.5%

We focused very hard on our CQUIN indicators and delivered the vast majority, securing £4.1m of income in the process in addition to providing improvements in care. Having successfully reduced agency staffing expenditure in 2017/18 by £4m it increased by 11% over the past year. We continue to focus on recruitment and retention of staff to reduce the need for agency staffing, but there are a number of staff shortages for a range of professions both locally and nationally. Our delivery of cost improvement projects was higher than plan at £10.6m.

Our focus on mandatory training is strong with positive achievement against our targets for completion. We played close attention to training on aggression management and moving & handling in recognition of the importance of both and the need to support our staff. The target was achieved for both. .

We compare favourably with other trusts of our type when it comes to sickness absence and reduced the level of sickness from 5.2% to 5.0% over the course of the past year. We want to improve further and we are working closely with our staff and staff-side representatives to improve the health and wellbeing of our staff

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 Board 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'. During 2018/19, we have continued to review our strategy and strategic direction regularly to ensure that it is aligned and responsive to internal and external factors. We pride ourselves on 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

For 2019/20, we have added a fourth objective to make the Trust a great place to work.

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 2018/19 we made the following progress against the achievement of our three strategic objectives:

Working in Partnership

During 18/19 we have undertaken a significant amount of work in integrated care partnerships in each of our four local areas.

In Barnsley we are a key partner within the Barnsley Health and Care Together Integrated Care Partnership which brings partners together from across the system to develop new models of care and integrated clinical pathways. We have taken a lead role in developing an

Integrated Care Delivery Group which the Trust chairs. This partnership group leads the work across the system on neighbourhoods, stroke, care homes, CVD, and frailty. Over the year we have worked in partnership to deliver an integrated network in one area of Barnsley which will be a useful foundation for the development of the Primary Care Network moving forward. This work has heavily involved the people of the community alongside staff from a variety of statutory and third sector organisations. Over the course of 18/19 we have worked with the local acute trust to integrate stoke services, this has included significant improvements to the pathway for people who have a Transient Ischaemic Attack.

We have worked with the system leadership **in Calderdale** to implement the single plan for Calderdale, Calderdale Cares, that sets out the vision to improve, health, social and economic outcomes for local residents. This work has focused on delivering shared outcomes building on the approach developed through the successful local vanguard. We have been partners in significant work to develop a locality focused way of working across Calderdale which brings together statutory and third sector partners around a particular community. This has included development of Primary Care Homes

In Kirklees a major focus of our partnership working has been around the development of an alliance of partners to deliver mental health service improvements for the people of Kirklees. Our role has been to help shape this alliance using learning from our work in Wakefield.

The **Wakefield** Integrated Care Partnership has continued to progress the integration agenda through the New Models of Care Board, underpinned by an alliance arrangement. The Mental Health Alliance has been established and systems and governance are in place to ensure that all partners are involved in the transformation and improvement. This work is led by the Trust through the newly created Provider Development Director role. Specific work has been undertaken on the personality disorder care pathway. This work has included strategic work as well as collaborative care planning to address the needs of particular people who require an integrated response to their needs. The Trust is also providing senior responsible officer leadership for the development of Primary Care Home (primary care networks) across Wakefield.

The Trust is an active participant of two Integrated Care Systems and we have continued to work with partners. In **South Yorkshire and Bassetlaw Integrated Care System** we have worked with partners on the Hyper Acute Stroke pathway in order to ensure that the people of Barnsley receive the best possible care if they have a stroke. In the **West Yorkshire and Harrogate Health and Care Partnership** we have been involved in a range of work and have led work streams on suicide prevention, autism, learning disabilities, and forensic mental health.

In 2018/19 the Trust completed its first year as host of the Learning Disability Operational and Delivery Network (ODN) for Yorkshire and the Humber.

In addition to our strong partnership working at a wider system level, we continue to work effectively and collaboratively to join up care with partner organisations and communities at local and service level.

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 which include:

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

In addition the Trust has in place a suicide prevention strategy which includes key actions.

The Learning from Healthcare Deaths policy lays out the Trust's process for reporting deaths and which deaths will be in scope for review. It describes responsibilities, including those of the Trust Board who are accountable for ensuring compliance with the 2017 National Quality Board guidance on Learning from Deaths.

The Trust has been working towards achieving the highest standards in mortality governance; and an internal audit in Spring 2018 gave significant assurance of our policy and processes.

The Trust Board recently approved an update to the policy which included;

- Inclusion of enhanced support for bereaved families in line with July 2018 national guidance. It includes the principles we will use and guidance for staff with links to online resources
    - Changes in response to feedback from internal audit; includes use of term 'case record review' and recognition of our 48 hour managers review on Datix is a first stage case record review.
    - Minor improvements to refine processes, reflecting our learning since introduction in 1 October 2017.
    - Updated governance section to reflect the introduction of our new Clinical Mortality Review Group.
    - Changes to the document structure to aid reading and improve understanding for staff, including updated flowcharts, terminology and additional definitions.

The Trust has benefited from working with a northern alliance of mental health trusts to develop the principles and scope of reviews. The agreement was for the policy to be 80% across the group with a local 20% to meet the specific organisation process and requirements. This ratio continues and the scope has not changed.

The policy, reporting dashboard and themes are publically available on the Trust website.

Our plans for the forthcoming year include;

- Work continues to develop support materials for bereaved families. A task and finish group has met to develop our plans for implementing the National Quality Board guidance on 'Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers' to align with the principles set out in the policy.
    - The policy acknowledges the importance of maintaining a focus on the desired outcomes rather than the process and this continues to be the case.
    - Our new Clinical Mortality Review group examines themes arising from reviews. This will support the key messages for sharing and implementation of learning across the Trust.

Work continues in conjunction with the both the Northern Alliance of mental health trusts and the Improvement Academy Regional Mortality group to develop work on outcomes from the reviews/investigations and consider how to work together on themes and trends.

Quality
In November 2018 we formally launched our #allofusimprove campaign which builds on the agreed Trust quality strategy and integrated change framework. The approach sets out to:

- support all our staff to improve and aim to be outstanding.
- help us demonstrate that we're an organisation that's continually improving.
- makes an even bigger difference to the lives of the people of Barnsley, Calderdale, Kirklees and Wakefield.

We have purchased 250 licences for people to undertake the Institute of Health Improvements on line training in order to increase capability and capacity for quality improvement in the Trust

Leadership and Management Development
We have continued to deliver the leadership and management development actions identified within the workforce strategy. This has included:

- integrating succession planning into our workforce planning approach
- increasing the number of trained coaches in the Trust
- Commencing leadership & management apprenticeship diploma programmes, Mary Seacole Local programmes and Moving Forward programme in line with our 'Leaders & Managers Development Pathway'.

Improving resources

In 2018/19, the Trust has undertaken significant work to improve our use of resources. This includes:

Use of agency staff
During 2018/19, we continued to focus on agency spend. In total it increased from £5.8m to £6.5m year on year which was largely due to the requirement for additional medical locums in a number of specialised services. Use of nursing agency staff was at a very similar level to the previous year and we have controls and processes in place to ensure we only use agency staff when it is needed. 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 £6.5m is 24% higher than the cap set by NHS Improvement. We have recently met with NHS Improvement's national team to identify areas where we can improve further.

Use of out of area placements
The use of out of area bed placements has continued to be 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 well above the number of beds we have internally. Expenditure on out of area bed placements for adult acute and PICU service users totalled £3.9m in the year and amounted to 4,904 days. During the year we worked with our West Yorkshire commissioners to develop a specification for use of external independent expertise to review our bed management processes and what can be done to improve them and therefore reduce the number of people going out of area.

Achievement of Financial Control Total
During 2018/19, we over-achieved against our financial control total of £2.0m deficit target set by NHS Improvement, delivering a £1.56m deficit. This achievement was made possible by a range of non-recurrent measures such as the sale of trust property no longer required, income support from our commissioners and careful management of discretionary spend.

The underlying financial position was actually a higher deficit of over £4m. Achievement of our target entitled us to access additional funding by means of the Provider Sustainability Fund (PSF) of £4.7m.

Clinical record system
During 2018/19 the Trust has introduced a new clinical record system for mental health services. This has involved significant change management and complex programme management in order to transfer services from RiO to Systmone. The Trust went live in our inpatient services on the 25th February 2019 and our community services on the 4th March 2019.

Digital health
We have continued to work with ORCHA to develop 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 service users to achieve positive outcomes and live life to the full whilst reducing unnecessary clinical variation.

We believe strong clinical leadership, supported by opportunities for innovation, continuous improvement 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. The Clinical Governance and Clinical Safety Committee reports directly to the Trust Board (see page 51) and the lead is the Executive Director of Nursing & Quality in partnership with a Non-Executive Director. A number of standing sub-groups which cover quality and safety areas are chaired by the Medical Director, Director of Nursing and Quality or their deputies and report directly into the Clinical Governance and Clinical Safety Committee. Quality improvement is routinely reported to our Trust board through our Integrated Performance Report.

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

Throughout 2018/19, 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 Report 2018/19. Below is a summary of our performance against 2018/19 quality priorities:

	No. of priorities	RAG rated summary of performance
Safe	5	5 rated green, 0 rated amber, 0 rated red
Effective	5	4 rated green, 1 rated amber, 0 rated red

	No. of priorities	RAG rated summary of performance
Caring	5	4 rated green, 1 rated amber, 0 rated red
Responsive	2	2 rated green, 0 rated amber, 0 rated red
Well Led	2	2 rated green, 0 rated amber, 0 rated red
Total	**19**	**17 rated green, 2 rated amber, 0 rated red,**

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

Our financial performance 2018/19

This section and the accounts have been prepared in line with appropriate guidance including the Group Accounting Manual for NHS Foundation Trusts 2018/19 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 £224.8m in 2018/19, which was £1.9m (0.8%) higher than the annual income in 2017/18. £207.3m (92%) 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 Provider Sustainability Fund. The majority of contract income is commissioned as a fixed payment; however 2.5% (£4.2 million for 2018/19) is based on the achievement of key quality indicators. The Trust has provisionally achieved 98% of these quality indicators.

	Year Ended 31 March 2019 £000s	Year Ended 31 March 2018 £000s
Income from patient care activities	207,321	208,032
Other operating income	17,460	14,848
Operating Income from continuing operations	**224,781**	**222,880**
Operating Expenses	(230,959)	(215,451)
Operating surplus/(deficit)	**(6,178)**	**7,429**
Finance income	162	66
PDC Dividends payable	(3,156)	(3,393)
Net Finance costs	**(2,994)**	**(3,327)**
Gains/(losses) on disposals of assets	500	425

	Year Ended 31 March 2019 £000s	Year Ended 31 March 2018 £000s
Surplus/(Deficit) for the Year	**(8,672)**	**4,527**
Impairments	(14,707)	(1,719)
Revaluations	0	9,841
Total Comprehensive Income (Expense) for the year	**(23,379)**	**12,649**

In total the Trust delivered a deficit of £23.4m in the year. It must be emphasised that £26.6m of this was driven by a revaluation downwards of the properties we own. This was because the cost of rebuilding some of our facilities, on which their value is based, has fallen by applying the latest clinical and organisational approaches. In addition it should be noted that the Trust received non-recurrent Provider Sustainability Funding (PSF) from the Department of Health of £4.7m given the fact that we achieved our financial targets for the year.

In light of the continued financial pressure in the NHS and wider public sector combined with known changes in some of our service provision and ongoing increases in demand 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. We now need to ensure we have sufficient measures in place to ensure our services remain financially sustainable.

There are various levels of surplus or deficit referred to in this report. The following table provides a reconciliation between the total comprehensive expense for the year of £23.4m as noted above and the £1.6m deficit reported in our management accounts:

	£m
Total Comprehensive Income/(Expense)	(23.4)
Impairments and Revaluations	14.7
Net Impairments	11.9
Provider Sustainability Funding (PSF)	(4.7)
Pre PSF Deficit in our management accounts	(1.6)

Operating Expenses

Our operating expenses were £231.0m, which compares to £215.5m in the previous year. The main reason for the increase being a net impairment of fixed assets of £11.9m. £167.9m of the total cost is attributable to employee costs, which is £1.6m higher than the value of spend in the previous year following the impact of pay inflation offsetting cost savings and reductions in income for some services. As with any year a number of events and issues materialised which led to variations in financial performance across the year. One such example continues to be the use and associated cost of out of area bed placements. Demand was particularly high in the first part of the year and was constantly higher than our internal bed capacity. We were successful in virtually eliminating the need for out of area placements in our Wakefield services in the second half of the year and consistently do not require them for our Barnsley services. We need to focus on having

similar success in our Kirklees and Calderdale services. The total spend for out of area beds amounted to £3.9m, which is a little higher than the amounts incurred in the previous two years. 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. Along with our West Yorkshire commissioners we did engage independent expertise to review our bed management processes in the latter part of the year. This has led to several improvement opportunities being identified which are currently being worked upon with the aiming of reducing the number of times people need to be placed out of area.

Another notable area of spend is that of temporary staffing. The agency ceiling set by NHS Improvement for 2018/19 was £5.3m This meant a further reduction was needed in order to meet it given the fact our agency costs in 2018/19 were £5.8m. We actually spent £6.5m, which represents an 11% increase year on year. This was mainly a result of the additional need for medical locums in a number of specialised services.

Cost Savings

In order to achieve our financial targets in-year savings of £9.7m were planned for. Savings of £10.6m were delivered, meaning additional savings compared to our plan largely as a result of revaluing a number of our buildings downwards and therefore charging lower depreciation. Of the £10.6m achieved £7.9m (75%) was delivered recurrently, with a further £2.7m achieved non-recurrently through specific mitigations such as reducing discretionary spend.

Capital

Our capital budget for the year was £8.3m and we invested in line with this plan. The focus of the programme included the completion of the second phase of the Fieldhead Non Secure re-development (£4.5m), the implementation of our new clinical record system for mental health, IT infrastructure and a range of minor capital works across our estate.

Cash

The closing cash position was higher than plan at £27.8m. This was largely due to an improved year-end position, the timing of capital expenditure, and continued focus on working capital management. Cash is expected to reduce next year as major capital development work concludes.

Outlook

2019/20 will continue to present a financial challenge for the Trust. We have been boosted by notable income growth for the first time in a number of years, but the underlying deficit needs to be addressed. At the same time demand and cost inflationary pressures continue. For 2019/20 over £12m in financial improvement is required to come close to a break-even position. In addition to securing income growth 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. Due to the deficit position and continued capital investment cash has been closely monitored and no investment was made during 2018/19. In total £162k interest income was earned during the year compared to £66k in the previous year due to increased cash and improved interest rates in the main bank account.

The Trust makes payments in line with the NHS Better Payment Practice Code (payment within 30 days of a valid invoice)

	NHS		Non NHS	
Total trade invoices paid in the year	667	12,552	33,026	86,224
Total trade invoices paid within target	701	13,286	32,375	84,928
Percentage of trade invoices paid within target	95%	94%	98%	98%

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 2018/19. These were updated for any changes in national guidance. This included incorporation of changes in the following standards:

- IRFS 9 Financial instruments – changes to the Trust policy on recognition of outstanding debts
- IRFS 15 Revenue recognition – no material impact on the Trust
  No changes have yet been required for IRFS 16 (leases) but these workings have been undertaken in shadow form.

Valuation of assets

In line with the Trust's accounting policies, a periodic review of Trust estate has been conducted in 2018/19. This was conducted by senior Trust staff and guidance was sought from the district valuer. For 2018/19 this consisted of a holistic review of our land and building valuations which ultimately resulted in a reduction in valuation of £26.6m. 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 2019 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 is 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 Ey Up! charity as well as the linked charities, Creative Minds, Spirit in Mind and the Mental Health Museum. Its objective is to promote the effective administration and management of the Trust's Charitable Funds, ensuring that those funds are used effectively to meet the objectives of the respective charities. The Trustee's actions are guided by a commitment to ensure:

- funds are expended for the purpose for which they were donated;
- accurate documentation of donor wishes
- compliance with statutory duties and Charity 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 continued to develop services during 2018/19. In line with our agreed Integrated Change Framework some of these changes are small scale and local, others cover more than one service and some span the whole Trust. Our 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 2018/19 include:

- a series of celebrations developed by staff and service users to recognise that one of our wards has been open for 10 years
- special themed food provided by our catering staff for specific dates such as Halloween and Valentines day
- a German style market raising money for our charity

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 2018/19 include:

- Establishing pain programmes for people with musculoskeletal pain which promote peer support and have received really positive feedback
- Staff and service users working together to run a shop in our medium secure services so that service users can easily buy the essential items they need
- Creating a pictorial menu for people in our learning disability services who were struggling with the written one.

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

- Development of chaotic lifestyle/personality disorder support with our partners in Wakefield
- Significant engagement with service users and commissioners across all localities to co-create the local change programme.
- Development of a new Single Transient Ischaemic Attack pathway with partners in Barnsley
- Work across both South Yorkshire & Bassetlaw and West Yorkshire & Harrogate on suicide prevention. In West Yorkshire this has resulted in Highways England progressing works on a bridge to reduce the chances of people being able to take their own life in this high profile place
- Introduction of a significant event analysis tool, developed in the Trust, which incorporates human factors.

Successful bids
In 2018/19, the Trust has been successful in a number of bids to retain or expand service provision.

In 2018, the Trust successfully bid to retain delivery of the **Improving Access to Psychological Therapies (IAPT)** service in Barnsley, with the new service commencing in July 2018.

We worked in partnership with Touchstone to successfully bid for the **South Yorkshire Liaison and Diversion service**, retaining our existing service in Barnsley and expanding delivery to Rotherham, Sheffield and Doncaster from 1 April 2019.

The Trust successfully bid to the Department of Health "**Beyond Places of Safety**" capital scheme to expand provision of high quality services to those experiencing a mental health crisis. Work was undertaken in 2018/19 to make improvements to the 136 suite and crisis assessment rooms in Calderdale.

2018/19 has seen the implementation of a new **Forensic Outreach and Liaison Service** across West Yorkshire, and agreement of funding for this service for 2019/20.

We have worked to maximise opportunities presented through working in partnership, securing income to support the ICS **suicide prevention strategy** by training our partners in suicide awareness and intervention and leading a successful bid on behalf of the ICS for Wave 2 funding from NHSE to further implement Individual Placement Support across West Yorkshire.

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

In 2018/19, we continued our work and planning to improve our **older people mental health service.** This has included engaging with service users, carers and our partners. .

Working within the Barnsley and Kirklees systems we have made improvements to our Improving Access to Psychological Therapies (IAPT)

We were also successful in securing a contract to provide Liaison and Diversion services across South Yorkshire.

We commenced our recruitment into the Forensic Outreach Liaison Services and this service will become fully operational in 2019/20

Care Quality Commission (CQC) inspection 2018

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' or '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 on-going complaints and serious incidents.

The outcome of the inspection was that our overall rating changed from Good to Requires Improvement. The CQC highlighted areas of strength and improvement, as well as areas of real challenge:

- 11 of 14 core services are rated Good – and all rated Good for being caring
- More than 85% of individual domains rated Good or Outstanding (60 out of 70)
- Overall, we're rated Good for well-led, caring and effective domains, and Requires Improvement for safe and responsive domains

We addressed safety issues first and foremost and responded in line with our values. Our ratings can be found on the subsequent pages.

When the CQC visited our wards in March 2018 we received an 'inadequate' rating for safety on our acute wards for adults of working age and psychiatric intensive care units. We were disappointed by this rating as we do not believe it reflects the hard work, caring attitude and commitment to quality that our staff demonstrate on a day to day basis.

From the inspection visit we received 10 Must do actions and 11 Should do actions. We have reviewed our practice against all these actions.

The CQC said we MUST review how our staff adhere to Trust policy in the following areas:

- Care and treatment of people in seclusion
- Administration and documentation of rapid tranquilisation
- Safe management and recording of medicines
- Assess patients' risk at the intervals outlined in the trust policy
- Ensure our clinic room checks are carried out in line with Trust policies
- Section 17 leave forms in full and this reflects that patients and their carers understand their responsibilities and the requirements of the leave.

And, MUST also:

- Ensure that patients have easy access to summon assistance from their bedrooms across all wards.
- Ensure patients have sufficient access to therapeutic activity to meet their needs and support their recovery.
- Ensure patient and carer involvement in care and discharge planning is accurately reflected in records.
- Have systems and processes in place to monitor the performance of the ward effectively and are used to improve the care and treatment provided.

Focus on reducing demand on acute wards:
One of the Trust priorities for 2018/19 was to reduce demand on the acute inpatient areas. A priority programme of work was undertaken which included work on the wards such as criteria led discharge to reduce length of stay, as well as work with Intensive Home Based Treatment and community teams to manage people well at home and reduce the chance that they will need to be admitted. We have compared the systems in the different parts of the Trust and found good practice that we are sharing and areas where we will focus in the next phase.

This work is a very high priority for 2019/20. We have developed an evidenced based plan which aims to provide care closer to home and are now putting this into action. The work streams identified are:

- Appropriate inpatient stays

- Refining the criteria led discharge
- Looking at what happens to our discharge rates when some senior medics go on leave
- Having a consistent approach that keeps people as close to home as possible
- Effective gatekeeping of inpatient beds in Calderdale & Kirklees
- Reducing the number of people needing acute interventions in Calderdale & Kirklees
- Increasing income to address shortfalls
- Understanding, reporting and responding to data and information
- Enabling a strategic approach to deliver a low admission model – in particular this includes working with commissioners to look at the high numbers of referrals that are coming from some GPs and making sure that they have alternatives in place for people in their communities

Additional work to improve quality on acute wards:

- Trust wide physical health strategy has been developed
- Carer engagement
- Engaged with NHS Improvement on reducing restrictive practice interventions quality improvement project on Nostell ward. (This programme will be rolled out across all appropriate wards in SWYPFT)
- New approach to documenting and reviewing seclusion.

As these work streams begin to reduce demand on acute inpatient services, the ward sizes will be reviewed and where bed numbers can be reduced to improve quality and safety of care, we will do so.

Environmental matters - Working in partnership with our stakeholders

As an NHS organisation which spends public funds we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

With the rising cost of natural resources, it is vital for the Trust to work more sustainably and to make the most of its economic and environmental assets. Since its base year the Trust has exceeded its carbon reduction target with a reduction in emissions of 36.2% meaning 4,380 tonnes less Co2 is released into the atmosphere each year.

We consider the environmental impact in everything we do. All our new buildings are built to the latest insulation standards and all incorporate energy efficient features such as LED lighting and the latest energy efficient heating plant. On a similar theme much of our existing estate has been retro-fitted with energy efficient LED lighting.

The Trust is committed to sustainable transport. We are working to reduce the need for staff to bring their personal vehicle to work, to reduce the need to use their vehicle for business purposes and to promote awareness of the benefits of sustainable travel choices and reducing reliance on car travel. We also consider how we can avoid the use of vehicles where possible and are making better use of technology such that staff do not always have to travel to meetings.

A range of initiatives have been implemented in support of enabling an agile workforce which has benefits on the environment and also enables better use of staff time. The Trust's agile working team continues to support teams to become agile across the Trust. Typically this involves workshops tailored for individual teams and equipment deployment. As a consequence we now have 2,500 laptops used by staff to enable them to work in a more agile manner

The Trust has worked with partners to support reciprocal Wi-Fi sharing arrangements to allow staff to work from partner sites rather than return to base during and after meetings.

Whilst we have made good progress in reducing our overall environmental impact we recognise that more needs to be done. There are a number of key areas of focus that will enable us to do this which are:

- Effective energy management and use of green technology
- Reduction in waste and improving recycling
- Procurement
- Behavioural change

In respect of our procurement activities we continue to build on the work of previous plans to procure our services using the whole life costing model. We monitor the use of local SME (Small, Medium Enterprises) suppliers and work proactively to maintain and increase engagement with these organisations. Any contracts which are tendered for are conducted via the Trust's e-Tendering portal and are advertised on *"Contracts Finder",* the recommended website for advertising public sector contract opportunities to local community suppliers. In addition, all tenders include a section on sustainability which requests the submission of a statement from the bidder on their organisations position linked to the Good Corporate Citizen concept.

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 18/19 these partnerships have strengthened considerably and the work has increased in pace.

In South Yorkshire and Bassetlaw Integrated Care System we have worked with partners on:

- the Hyper Acute Stroke pathway
- the development of neighbourhood care in Barnsley

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

Joined with other mental health providers to focus on the following areas of improvements:

- Use of out of area bed placements;
- 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;
- Learning Disabilities
- Mental Health rehabilitation and out of area high cost placements.
- Harnessing the power of communities, including a carers programme and the 'Look out for your Neighbours' campaign that aims to reduce loneliness

The Trust is also a key partner within the Integrated Care Partnerships in each of the four districts where we work.

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 areas for improvement.

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
- 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 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 83).

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.

Looking ahead – our strategy objectives

Our strategic objectives in 2019/20 will focus on the quadruple aims: improving people's health and wellbeing; improve the quality and experience of all we do; improve our use of resources; and making the Trust a great place to work. We have identified a number of priority programmes that will enable the Trust to continue to drive improvements and deliver the Trust strategy.

The Trust's plan for 2019/20 sets out an in-year planned deficit (pre Provider Sustainability Funding) of £0.2m which has been agreed with 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 £0.2m means that we will need to deliver a challenging cost improvement in 2019/20. Our financial plan assumes cost savings of £10.7m. All are subject to a quality impact assessment and significant programmes will be established with robust project management arrangements.

For 2019/20, there are a number of key areas of focus which will help drive financial improvement:

- **Income growth**: the level of investment in mental health and community health services is increasing in 2019/20 and working with our commissioners we have agreed priorities for where this investment can best be applied.
- **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. There have been some improvements in the past year, but the use of out of area placements has continued. Based on the recommendations following an independent review a number of actions have been identified to make improvements.
- **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, including staff in non-clinical roles and by focusing on productivity. Additional savings are possible and are being factored into our plans. Wherever possible we will utilise vacancies to reduce staffing, to minimise disruption and redundancy costs.
- **Non-pay and contracts:** We continue to place 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.
- **Eliminating waste**: we are working to reduce waste in everything we do and to increase productivity by identifying and learning from best practice.

Details of any overseas operations

The Trust does not have any overseas operations.

Rob Webster
Chief Executive Date: 23 May 2019

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 tables from page 38.

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 2019 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 the 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 2019 was as follows.

	Total	**Male**	**Female**
Non-Executive Directors	7	1 (14%)	6 (86%)
Executive Directors	5	4 (80%)	1 (20%)
Other Directors (non-voting)	3	1 (33%)	2 (67%)

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

No political donations have been made.

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 2018 was reported to the Members' Council at its meeting in February 2019.
- 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.

The Chair also holds quarterly meetings with the Non-Executive Directors without the executive Directors present.

Trust Board 2018/19

Role/name/appointment	Experience	Public Board attendance 2018/19
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.	8/8
Deputy Chair / Senior Independent Director **Charlotte Dyson**  Appointed 1 May 2015 to 30 April 2018 Deputy Chair / Senior Independent Director from 1 August 2017 to 31 July 2018 Re-appointed 1 May 2018 to 30 April 2021	• 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.	8/8
Non-Executive Director **Laurence Campbell** 	• 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.	7/8

Role/name/appointment	Experience	Public Board attendance 2018/19
Appointed 1 June 2014 Re-appointed 28 April 2017 to 31 May 2020		
Non-Executive Director **Rachel Court**  Appointed 1 October 2015 to 30 September 2018 Re-appointed 1 October 2018 for up to 12 months, term ended 31 March 2019	• 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.	7/8
Non-Executive Director **Erfana Mahmood**  Appointed 3 August 2018 to 2 August 2021	• Qualified Solicitor • Experience in the housing sector. • Non-Executive Director for Chorley and District Building Society • Non-Executive Director for Plexus/Omega Housing (part of the Mears Group).	5/5
Non-Executive Director **Kate Quail** 	• Experienced, qualified Public Health professional with deep understanding of social determinants of health & wellbeing. • Previously Head of two Department of Health National Support Teams, including one for Children and Young People's Emotional Wellbeing and Mental Health. • Experienced in putting people with learning disability and/ or autism and/ or mental health problems & their families and carers at the centre. For example:	7/8

Role/name/appointment	Experience	Public Board attendance 2018/19
Appointed 1 August 2017 to 31 July 2020	• Member of Advisory Group to Improving Health and Lives Learning Disability Observatory (Public Health England until March 2019). • Original national Transforming Care steering group member. • Expert for Care & Treatment Reviews and Care Education & Treatment Reviews • Extensive experience of working in partnership across whole systems. • In-depth experience of working in and with large complex organisations, from national & local charities and local community organisations, to Local Authorities, health organisations and Whitehall Departments • FT Governor for 5 years, including Lead Governor.	
Non-Executive Director **Sam Young**  Appointed 3 August 2018 to 2 August 2021	• Runs own consultancy business with a focus on technology and transformation. • Previously worked in the housing, local authority and IT sectors in a number of senior roles. Previous head of IT at Kirklees Council, worked for BT on NHS contracts and spent 2 years as a Director of Business Transformation at the New Charter Group. • Non-Executive Director at Great Places Housing Group.	5/5
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 & Harrogate Health & Care Partnership, 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	7/8

Role/name/appointment	Experience	Public Board attendance 2018/19
	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.	
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 Deputy Chief Executive from 9 July 2018	• Over 30 years' experience in the health and social care market with both public and private sector experience. • Executive Director experience in both public and private sector environments, including Managing Director of a Long Term Health Care PLC. • Significant senior management experience in both local authority and charitable sector at key points in career. • Five years' experience as a self-employed management and training consultant. • Director level responsibility for PLC acquisition and merger plan. • Significant experience in contract negotiation and delivery on contracts, including the delivery of capital investment programme to support growth. • Lead professional adviser on learning disability policy, strategy and commissioning for both PCT and local authority. • Well documented history of partnership working, including the chairing of multi-agency partnership boards. • Nurse leadership roles in a variety of care and support settings.	8/8
Director of Finance and Resources **Mark Brooks**  Appointed 1 June 2016	• 9 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.	8/8

Role/name/appointment	Experience	Public Board attendance 2018/19
Director of Human Resources, Organisational Development and Estates **Alan Davis**  Appointed 1 April 2002 Interim Deputy Chief Executive 1 April to 31 August 2016 Interim Deputy Chief Executive 1 July 2017	• 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. • 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.	8/8
Medical Director **Subha Thiyagesh**  Appointed 19 April 2018	• Doctorate in Medicine in the dementia field from the University of Sheffield. • Previously deputy medical director and a consultant in older people's services in Calderdale and Kirklees for the Trust. • Previous posts include being appointed to the Royal College of Psychiatrists' Board of Examiners and as a national peer reviewer of the Memory Service National Accreditation Programme. • Subha is the clinical lead for our older people's change programme and has been leading the development of our medical workforce strategy. • Awarded the Nye Bevan NHS Leadership Academy Award in Executive Healthcare Leadership and was the winner of the Leader of the Year award in our Trust's Excellence awards in 2016.	6/8

Other Directors (non-voting)*

Role/name/appointment	**Experience**	**Public Board attendance 2018/19**
Director of Operations (non-voting) **Carol Harris**  Appointed District Director – Forensic and Specialist Services from 21 March 2016 District Director – Forensic and Specialist Services, Calderdale and Kirklees from 1 October 2016 Director of Operations from 1 August 2018	• 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.	7/8*
Director of Provider Development (non-voting) **Sean Rayner**  Transitional post as District Director, Barnsley from 22 February 2011 Substantive District Director – Barnsley and Wakefield from 1 April 2012 Director of Provider Development from 1 August 2018	• 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 formerly a member of HMP Wealstun Independent Monitoring Board (IMB).	7/8*

Role/name/appointment	Experience	Public Board attendance 2018/19
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 developing partnership, transformation and innovation.	7/8*

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

The following members left office during 2018/19:

Role/name/appointment	Experience	Public Board attendance 2018/19
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.	1/3
Medical Director **Adrian Berry**  Appointed Director of Forensic Services 1 November	• 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.	0/0

Role/name/appointment	Experience	Public Board attendance 2018/19
2010 Medical Director 1 October 2014 to 31 March 2018 Deputy Chief Executive from 1 October 2016 to 30 June 2017 Retired from director role on 31 March 2018		
Director of Communications, Engagement and Commercial Development (non-voting) **<u>Kate Henry</u>**  Secondment 26 May 2015 to 31 March 2016 Fixed term contract from 1 April 2016 to 31 March 2017, extended to 30 June 2018, extended to August 2019 (maternity leave to August 2019)	• 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.	2/2*
Director of Delivery (from 1 October 2017) (non-voting) **<u>Karen Taylor</u>**  Interim appointment 9 January 2012 Substantive appointment 1 April 2012 Retired 31 August 2018	• 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.	3/3*

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

All voting directors have a six month notice period whilst non-voting directors have a three month notice period. The Medical Director has a Consultant Contract.

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 April 2018 the CQC carried out a well-led review of the Trust and this will be followed up by a further review in June 2019 when the CQC will carry out an inspection of the Trust and a well-led review. 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 Workforce and Remuneration 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 2019. 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 five times in 2018/19 and its membership was as follows:

Name/role	Attendance 2018/19
Laurence Campbell, Non-Executive Director - Committee chair	5 / 5
Rachel Court, Non-Executive Director	4 / 5
Chris Jones, Non-Executive Director* (member to 31 July 2018)	2 / 3
Erfana Mahmood, Non-Executive Director* (*member from 25 September 2018)	1 / 2
Sam Young, Non-Executive Director* (*member from 25 September 2018)	2 / 2

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 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 2018/19. 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 changes to accounting policies at its meeting in January 2019. These changes were supported by the Trust's external auditor.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and	The Committee recommended to the Trust Board for approval the annual report, accounts and Quality Account for 2017/18 at its meeting in May 2018 prior to submission to NHS Improvement (Monitor). As part of the consideration of the auditor's report, the Committee received and reviewed the

Financial reporting	Progress
associated documents prior to submission.	Use of Resources Assessment for 2017/18. The Committee also reviewed the external audit report on the production of the Quality Account for 2017/18. *(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 recommended for approval the stand-alone annual report and accounts for charitable funds in October 2018.
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 reviewed the Treasury Management Policy and Strategy in January 2019 and supported its approval by Trust Board. An update is provided at each Committee meeting. The Committee also receives a detailed report on procurement activity at each meeting, which monitors non-pay spend and progress on tenders, the use of single tender waivers, 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 (private item). 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 2017/18.
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.	The Committee last reviewed the Standing Financial Instructions in October 2016 and supported their approval by 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 April 2019 and approved by the Trust Board in April 2019 and Members' Council in May 2019. They will next be due for review in 2021. There were no occasions when Standing Orders were waived in 2018/19. 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 understatement of provision balances, accounting for property valuations, and management override of controls. 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 2018/19.

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. In April 2018, the Members' Council confirmed that the contract with Deloitte for provision of external audit services continues for a further two years, therefore until 30 September 2020.
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 2018. 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 2018. 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 2017/18 accounts; ➢ final reports and recommendations as scheduled in the annual plan.
Review of each individual provision of non-audit services by the external auditor in respect of its effect on the appropriate balance between audit and non-audit services.	Deloitte has not been engaged to provide any non-audit services during 2018/19

The Audit Committee has a number of responsibilities in relation to the Trust's counter fraud and internal audit functions. These are set out in the following tables with information on how these have been addressed during 2018/19.

Counter Fraud	**Progress**
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	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 April 2018 and May 2018, 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 2017/18 in July 2018.
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.	Through a procurement framework and tender process, 360Assurance 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 2018/19 was presented to and approved by the Committee in April 2018. 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 Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2017/18. This provided significant assurance. 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. Relating to 2018/19, 11 internal audit reports were presented to the Committee. Of these, there were: - 9 'significant assurance' reports; - 2 'limited assurance' reports (New Clinical Information System, Patient Experience - Complaints). 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.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The on-going 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. The Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit.

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 Board Assurance Framework (BAF) 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 six times in 2018/19 and its membership was as follows:

Name/role	Attendance 2018/19
Charlotte Dyson, Deputy Chair of the Trust - Committee chair	6 / 6
Angela Monaghan, Chair of the Trust	5 / 6

Name/role	Attendance 2018/19
Kate Quail, Non-Executive Director	6 / 6
Tim Breedon, Director of Nursing & Quality - lead Director	6 / 6
Dr Subha Thiyagesh, Medical Director	4 / 6
Alan Davis, Director of Human Resources, Organisational Development & Estates	4 / 6

The Director of Operations (previously Business Delivery Unit (BDU) Director) continues to attend the Committee to ensure strengthened operational input and to enable the Committee to gain assurance more effectively.

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 four times in 2018/19 and its membership was as follows:

Name/role	Attendance 2018/19
Chris Jones, Non-Executive Director - Committee chair* (*to 31 July 2019)	1 / 1
Kate Quail, Non-Executive Director - Committee chair * (*member to 31 July 2018, chair of committee from 1 August 2018)	4 / 4
Laurence Campbell, Non-Executive Director	2 / 4
Erfana Mahmood, Non-Executive Director* (*member from 25 September 2018)	2 / 2
Dr Subha Thiyagesh, Medical Director - lead Director	4 / 4
Tim Breedon, Director of Nursing and Quality	4 / 4
Salma Yasmeen, Director of Strategy	4 / 4

In 2018/19, the Committee gained greater senior operational representation, with the Trust's Director of Operations (previously Business Delivery Unit Director) now attending meetings to enable the Committee to gain assurance of the operational action being taken to improve performance. Representatives of the four local authorities (LAs) and three acute trusts covered by the Trust's geographical area are invited to attend. The acute hospitals have an agreement by which one attendee represents them all. In 2019/20, a new process will be developed to ensure every local authority provides information to each Mental Health Act Committee meeting, to highlight good practice and provide valuable challenge and scrutiny. The Committee invites the Chair of the Hospital Managers' Forum to attend each meeting. The Assistant Director, Legal Services, and Clinical Legislation Manager also attend each meeting to provide expert advice and support to the Committee.

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 Directors and Non-Executive Directors.

Other Board-level Forums

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 the Trust Chair and has non-executive and executive Director membership and a governor member. Invited attendees include a Human Resources lead, Equality and Engagement lead, and a Staff Side Equality lead. A proposal was approved by Trust Board in April 2019 for this Forum to become a standing committee of the Trust Board.

Members' Council

For the Members' Council role in governance arrangements, refer to section NHS Foundation Trust Code of Governance (see page 73).

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, Care Quality Commission inspections). 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, 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 2018/19.

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 reports, and reports arising from the Care Quality Commission (CQC).

Patient care

One of the quality domains is ''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 2018/19 were:

- Friends and Family Test.
- Develop volunteering strategy to support service user experience.
- Development of professional strategies

Further information is within the Quality Accounts for 2018/19.

The Trust continues to work in partnership with its staff, stakeholders and partners. Key activity during 2018/19 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 16).

Rob Webster
Chief Executive Date: 23 May 2019

Section 2.2 Remuneration report

Annual statement on remuneration

The Trust's remuneration policy remains that the terms and conditions for staff reflecting 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 Workforce and Remuneration Committee for staff above 8b.

The Trust operates a local Clinical Excellence Award Scheme for consultant medical staff based on the previous national employer-based awards scheme. 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 clinical excellence awards were made this year, following the outcome of national discussions for 2016 and 2017.

The Chair of the Workforce and Remuneration Committee is able to confirm there is no longer a Directors' Performance Related Pay Scheme. No other major decisions on senior managers' remuneration were taken and there were no substantial changes made 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 Workforce and Remuneration Committee (previously 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 Workforce and Remuneration Committee determined the remuneration policy for directors with specialist external advice and/or external benchmarking reports as appropriate. Any significant changes in directors' remuneration is undertaken with the use of external benchmarking data and/or external specialist support again as appropriate. 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 60-62 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 2018/19.

The Chief Executive and the Medical Director are the only senior managers paid over £150k. The Workforce and Remuneration Committee considers both to be reasonable as the Chief Executive's salary 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 (voting directors) are subject to a six-month notice period, which was considered and approved by the Remuneration and Terms of Service Committee (now called the Workforce and Remuneration Committee) in February 2015. The notice period for other Directors remains as three months.

	31 March 2019	**31 March 2018**
Band of highest paid Director's total remuneration (£000's)	175 - 180	170 - 175
Median total remuneration* £'s	£28,847	£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

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 scale was approved by the Members' Council in July 2015. The expected time commitment for the Chair is 2.5-3.5 days per week

Annually, the remuneration of the Chair and Non-Executive Directors is reviewed by the Nominations Committee and any recommendation for uplift made to the full Members' Council for approval. In 2018/19, the Members' Council approved a 1.5% inflation uplift for Non-Executive Directors (not including the Chair) in line with the national award for consultants. Basic remuneration for a Non-Executive Director is £13,584 per annum against an expected time commitment of at least 2.5 to 3 days per month. The roles of Deputy Chair / Senior Independent Director and Chair of the Audit Committee receive and additional £5,000 per annum. Following the Chair's appraisal process for 2018, the Members' Council approved that the Chair move to the second point in the incremental 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

The Trust does not operate any performance related pay schemes.

Annual report on remuneration

Workforce and Remuneration Committee

The Workforce and Remuneration Committee (previously 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 five times in 2018/19 and its membership was as follows:

Name/role	Attendance 2018/19
Rachel Court, Non-Executive Director - Committee chair	5 / 5
Charlotte Dyson, Deputy Chair of the Trust	4 / 5
Angela Monaghan, Chair of the Trust	5 / 5
Rob Webster, Chief Executive - Non-voting member	4 / 5

The Chief Executive and Executive Directors are appointed by the 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 and Company Secretary also attend. 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 four times in 2018/19 and its membership was as follows:

Name/role	Attendance 2018/19
Angela Monaghan, Chair of the Trust - Committee chair	3 / 4
Rob Webster, Chief Executive* (*member to August 2018)	2 / 3
Jackie Craven, Lead Governor (public)	4 / 4
Nasim Hasnie, Governor (public)	2 / 4
Marios Adamou, Governor (staff)	3 / 4
Ruth Mason, Governor (appointed)	3 / 4

*following advice from NHS Improvement regarding membership of trust nominations committees, the Chief Executive is now an attendee of the Committee rather than a formal voting member which is consistent with other trusts.

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 2018/19, Chris Jones did not seek re-appointment as a Non-Executive Director at the end of his term on 31 July 2018 and Rachel Court agreed to remain on the Board up to 31 March 2019 following the end of her term on 31 August 2018, which was approved by the Members' Council on 27 April 2018. In 2018, recruitment for two new Non-Executive Directors took place with the appointment of Erfana Mahmood and Sam Young approved by the Members' Council on 3 August 2018 following recommendation by the Nominations Committee.

The Nominations Committee also reviewed the role of the Deputy Chair / Senior Independent Director at its meeting in April 2018 and made a recommendation for re-appointment of Charlotte Dyson, which was approved by the Members' Council on 27 April 2018 along with her re-appointment as a Non-Executive Director.

Disclosures required by Health and Social Care Act

In 2018/19 a redundancy payment was made to the Director of Delivery 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.

In 2018/19, 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: 23 May 2019

Name and Title	31/03/2019						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Angela Monaghan,Chair	40 - 45				3.9		45 - 50
Laurence Campbell, Non-Executive Director	15 - 20				0.9		15 - 20
Charlotte Dyson, Deputy Chair / Senior Independent Director	15 - 20				2.9		20 - 25
Rachel Court, Non-Executive Director (left 31/03/2019)	10 - 15				1.0		10 - 15
Christopher Jones, Non-Executive Director (left 31/07/2018)	0 - 5						0 - 5
Erfana Mahmood, Non Executive Director (from 06/08/18)	5 - 10				0.4		5 - 10
Kate Quail, Non-Executive Director	10 - 15				0.9		10 - 15
Samantha Young, Non Executive Director (from 06/08/18)	5 - 10				0.4		5 - 10
Rob Webster, Chief Executive	175 - 180	2.0				47.5 - 50.0	225 - 230
Adrian Berry, Medical Director / Deputy Chief Executive (left 11/04/2018)	0 - 5	0.7		0 - 5			5 - 10
Timothy Breedon, Director of Nursing and Quality / Deputy Chief Executive	120 - 125	1.6			0.4	72.5 - 75.0	195 - 200
Mark Brooks, Director of Finance and Resources	125 - 130				0.3	27.5 - 30.0	155 - 160
Alan Davis, Director of Human Resources, Organisational Development and Estates	110 - 115	0.9				5 - 7.5	120 - 125
Carol Harris, Director of Operations	100 - 105				0.6	20.0 - 22.5	125 - 130
Kate Henry, Director of Marketing, Engagement and Commercial Development	60 - 65				0.1		60 - 65
Sean Rayner, Director of Provider Development	105 - 110	1.7		0 - 5		32.5 - 35.0	140 - 145
Karen Taylor, Director of Delivery (left 05/08/2018)	50 - 55			160 - 165	0.3		210 - 215
Subhashini Thiyagesh, Medical Director (from 12/04/2018)	35 - 40	4.4		115 - 120	3.1	97.5 - 100.0	260 - 265
Salma Yasmeen, Director of Strategy	100 - 105				0.1	62.5 - 65.0	160 - 165

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	31/03/2018						
	Salary (bands of £5000) £000	Taxable Benefits Rounded to 1 decimal place £000	Annual Performance related bonuses (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expenses Rounded to 1 decimal place £000	Pension - Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Ian Black, Chair (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 and 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

Name and title	Normal retirement age	Real increase/ (decrease) in pension and related lump sum at retirement age (bands of £2500) £000	Total accrued pension and related lump sum at retirement age at 31 March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Increase (Decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension Rounded to 1 decimal place £000
Adrian Berry, Medical Director / Deputy Chief Executive (left 11/04/2018) *	55	(27.5) - (30.0)	285 - 290	0	0	0	0
Timothy Breedon, Director of Nursing and Quality / Deputy Chief Executive	65	7.5 - 10.0	105 - 110	817	654	144	0
Mark Brooks, Director of Finance and Resources	65	0 - 2.5	20 - 25	309	235	66	0
Alan George Davis, Director of Human Resources, Organisational Development and Estates	60	2.5 - 5.0	225 - 230	1,385	1,209	140	0
Carol Harris, Director of Operations	60	5.0 - 7.5	155 - 160	846	709	116	0
Kate Henry, Director of Marketing, Engagement and Commercial Development	60	(2.5) - (5.0)	10 - 15	121	130	(13)	0
Sean Rayner, Director of Provider Development	60	5.0 - 7.5	170 - 175	959	809	125	0
Karen Taylor, Director of Delivery (left 05/08/2018) *	55	7.5 - 10.0	195 - 200	0	0	0	0
Subhashini Thiyagesh, Medical Director (from 12/04/2018)	60	12.5 - 15.0	125 - 130	641	474	153	0
Rob Webster, Chief Executive	60	2.5 - 5.0	200 - 205	1,113	917	169	0
Salma Yasmeen, Director of Strategy	60	7.5 - 10.0	55 - 60	282	221	54	0

* Taken their Pension in 2018/19 therefore the CETV is nil

The cash equivalent transfer values for Rob Webster and Kate Henry as at 31 March 2018 have been updated following advice from the NHS Pensions Agency

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

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 2019 is outlined below. Information on average staff numbers can be found in the accounts.

	Total	**Male**	**Female**
Non-Executive Directors	7	1 (14%)	6 (86%)
Executive Directors	5	4 (80%)	1 (20%)
Other Directors (non-voting)	3	1 (33%)	2 (67%)
Staff	4,202	942 (22%)	3,260 (78%)

	Total Number	**Permanently Employed Number**	**Other Number**
Medical and dental	184	163	21
Administration and estates	1,022	988	34
Healthcare assistants and other support staff	769	591	178
Nursing, midwifery and health visiting staff	1,284	1,209	75
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	764	744	20
Social care staff	16	16	0
Other	0	0	0
Total	**4,039**	**3,711**	**328**

During 2018/19, on average, of 4,039 whole time equivalent (wte) staff were engaged, 3,711 were on permanent contracts, and 328 on 'other' contracts. This compares to 4,124 WTE in 2018/19 when there were 3,845 staff on permanent contracts and 279 on 'other' contracts.

Changes to our workforce reflect an on-going drive to improve efficiency, effectiveness and productivity, and arise from our cost improvement programme, our contract and tendering activity, and local and national investment priorities, such as Improving Access to Psychological Therapies, Early Intervention in Psychosis and child and adolescent mental health services.

The staff turnover rate for the Trust at 31 March 2019 was 11.9%%, which is lower than last year. Reducing turnover and increasing retention remains a key objective of the workforce strategy action plan.

Trust Board set a stretch target sickness absence rate of <=4.5%% for 2018/19; the Trust achieved a rate of 5.0%. Staff sickness data as required by the Cabinet Office will be published on the Trust's website.

The table below shows the staff in post by the different occupation groups as at 31 March 2019.

Staff in post by occupation group	**2018/19 FTE**	**2018/19 Heads**
Professional, scientific and technical	285	330
Additional clinical services	810	926
Administration and clerical	753	889
Allied health professions	278	328
Estates and ancillary	264	336
Medical and dental	142	157
Nursing and midwifery registered	1,124	1,261
Students	1	1
Total	**3,657**	**4,228**

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 2019) and those in the accounts represent an average over the financial year.

Equality and diversity			**Staff as at 31 March 2019**
Age Band	**Females**	**Males**	**Total**
19 and Under	7	6	13
20 – 29	423	73	496
30 - 39	741	187	928
40 - 49	841	293	1,134
50 - 59	953	303	1,256
60 - 69	297	84	381
70+	17	3	20
Total:	**3,279**	**949**	**4,228**

Census Group	**Grand Total**
Asian	4.6%
Black	2.7%
Chinese or Other	1.1%
Mixed	1.1%
White	90.2%
Unknown	0.3%
Grand Total	**100.0%**

During 2018/19 6 redundancies were actioned by the Trust (see below). The exit packages were made in accordance with nationally agreed arrangements. Information for 2017/18 is also included in the following table.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
<£10,000	0	5	0	5	0	10
£10,001 - £25,000	2	14	0	2	2	16
£25,001 - £50,000	3	5	0	0	3	5
£50,001 - £100,000	0	2	0	0	0	2
£100,001 - £150,000	0	1	0	0	0	1
£150,001 - £200,000	1	1	0	0	1	1
Total number of exit packages by type	6	**28**	0	**7**	6	**35**
Total resource cost £'000	308	**£893k**	0	**£67k**	308	**£960k**

In 2018/19 there were 0 'other' departures including contractual payments made to individuals in lieu of notice (6 in 2017/18).

Exit packages non-compulsory departure	Agreements/number		Total value of agreements £000	
	2018/19	2017/18	2018/19	2017/18
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	3	0	£34k
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	1	0	£5k
Exit payments following Employment Tribunals or court orders	0	3	0	£28k
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	**7**	0	**£67k**
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 2018/19 was £160k and the lowest was £14,311. This is against a high of £160k and low of £5,367 in 2017/18.

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 2018/19, the Trust has reported £105k of consultancy expenditure in relation to the provision of advice and guidance outside the normal course of business, which compares to expenditure of £265k last year. This spend is broken down into the following areas:

- £100k for support and review of our bed management processes with the aim of reducing out of area bed usage. 50% of this cost was funded by our West Yorkshire commissioners;
- Set up of the new liaison and diversion contract across South Yorkshire

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 an overarching Health and Safety and Emergency Planning Trust Action Group which includes staff side, managers and specialist advisers.

During 2018/19, we focused our staff engagement activities on supporting leadership and management development. This included a senior leader's forum 'Middle Ground' focussing on the development of healthy teams including active staff engagement. The Trust also conducted its Well-being at Work and engagement survey receiving 1700 responses.

Staff equality networks

We know that the people who work for us are our biggest strength and when they feel supported, we have a more motivated workforce which is better for service user satisfaction, care and safety.

We have a commitment to creating an inclusive Trust, and one of the ways we are doing this is through the development of staff networks. These networks are specifically intended to address distinct issues that underrepresented groups face, facilitate learning and development, and influence the Trust's direction through sharing experiences.

We continue to develop staff networks. Our **Black, Asian and minority ethnic (BAME) staff network** celebrated its second year anniversary in October 2018. An event to mark the occasion featured guest speaker Yvonne Coghill, director of the NHS Workforce Race Equality Standard and Beverley Powell, development manager national lead for inclusion and talent management at the Yorkshire and the Humber Leadership Academy. It focused on progress of the network including that seen in the NHS workforce standard. We have also made developments on two further staff networks - a disability staff network and LGBT+ staff network, and we're making progress on a carers staff network.

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 2018. The survey was sent to all staff. The response rate was 40%, which is below average compared with similar NHS organisations. However the Trust conducted its own Well-being at Work Survey in July/August 2018 with 1,700 responses which may have impacted on the response rate of the national survey.

Theme results	Trust 2018	Average 2018	Trust 2017	Average 2017	Trust 2016	Average 2016
Equality, diversity and inclusion	**9.2**	**9.2**	9.2	9.2	9.3	9.2
Health and Well-being	**6.1**	**6.1**	6.2	6.1	6.2	6.2
Immediate managers	**7.1**	**7.2**	7.0	7.1	7.1	7.1
Morale	**6.2**	**6.2**	N/A	N/A	N/A	N/A
Quality of appraisals	**5.5**	**5.5**	5.4	5.4	5.3	5.4
Quality of care	**7.2**	**7.4**	7.3	7.4	7.6	7.5
Safe environment-Bullying	**8.2**	**8.2**	8.2	8.3	8.2	8.2
Safe environment-Violence	**9.4**	**9.5**	9.4	9.5	9.3	9.5
Safety Culture	**6.7**	**6.8**	6.7	6.7	6.6	6.7
Staff Engagement	**6.8**	**7.0**	6.8	7.0	6.9	7.0

Actions 2018 NHS Staff Survey

There are no statistically significant changes in key theme results from 2017. Satisfaction with the quality of appraisal and support from immediate managers has increased by 0.1. Satisfaction with the quality of care provided and workplace health and well-being has decreased by 0.1 since 2017. The majority of key theme results are average compared to the Trust's benchmarking group. Satisfaction with the quality of care provided and level of Staff Engagement are 0.2 below average. In relation to the Trust's workforce strategy the Trust has agreed there will be four key areas of focus: Improving staff engagement, supporting workplace well-being and resilience, prevention of harassment and bullying and increasing the quality of appraisal.

Increasing staff engagement

Increasing staff engagement is a key strategic aim of the Trust's workforce strategy. In addition, the Trust's values, behaviours and leadership and framework all emphasise the importance of staff engagement. 'Middle Ground' which is a communication and engagement forum for senior leaders which ran in 2018 focussed on developing healthy and resilient teams. The forum also focussed on improving engagement, promoting health at work and encouraging positive behaviours. A benchmarking tool for assessing team working was used and a 'Middle Ground Plus' offer supports improvements in team working and staff experience. A revised 2019 Middle Ground will be offered focussing on these four key workforce priorities.

Improving workplace health and well-being
The Trust has invested significantly in the health and well-being of its workforce over a number of years. In 2018 the Trust conducted its latest well-being and engagement survey working with Robertson Cooper, Occupational Psychologists, and had 1700 responses.

Results indicated improvements since 2017 and showed typical levels of well-being and engagement across the Trust. Results are being used to target support. The Trust offers a specialist occupational health service, in house staff counselling service and staff retreats. Health and well-being checks are offered to staff.

Prevention of Bullying and Harassment
At a Trust level results indicate lower than average levels of bullying from managers to colleagues and also colleague to colleague. Bullying, harassment and abuse from patients/service users, relatives or members of the public is above average. A bullying and harassment action plan was agreed at the Workforce Remuneration Committee in February 2019. An engage and listen exercise is being conducted in early 2019 to highlight examples of positive practice and opportunities for improvement. A revised framework for the prevention of bullying will be produced emphasising this is everyone's role in the Trust.

Improving the quality of appraisal
The Trust's appraisal process was revised in 2018. Satisfaction with the appraisal process has increased overall since 2017. The appraisal process has been reviewed again to ensure it is user friendly and focussed on the quality of the appraisal discussion. The appraisal includes discussion around any health and well-being issues. The revised policy is being supported by training and learning opportunities.

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. Well-being at work surveys may be targeted this year to service areas requiring additional support.

Review of the NHS Staff Survey action plan

The Trust is developing an action plan in response to the NHS Staff Survey 2018, 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.

Workforce Report

Staff policies and actions
The Trust is recognised as a Disability Confident Employer which demonstrates the organisation's commitments in relation to recruitment, retention, employment and career development of people with a disability.

As part of being a Disability Confident Employer, the Trust operates a guaranteed interview scheme as specified in the Recruitment and Selection Policy for candidates who have a disability which falls within the definitions described in the Equality Act 2010 and subsequent amendments.

Candidates who have a disability will be offered an interview if they meet all the essential criteria detailed on the person specification for the post.

Additional information for disabled candidates is provided via a link on NHS jobs which provides a range of options to ensure that no barriers are created in the selection process e.g. specific assistance or adjustments.

The Trust's sickness and attendance policy and procedures are applied consistently and support the continuing employment of, and enable the provision of appropriate training for employees who have become disabled persons during the period.

In some cases it may be appropriate to consider making reasonable permanent adjustments to the employee's duties or work arrangements. Such adjustments may include those outlined previously as temporary adjustment.

It is particularly important to explore this option thoroughly when an employee's sickness is as a result of a disability, as defined under the Equality Act 2010. To conform to the requirements of the Act, careful consideration is given to making whatever reasonable adjustments are necessary to accommodate a disabled employee, if it is possible to do so in line with service need. Managers assess the feasibility of making the required adjustments for the service, colleagues and the employee, taking advice from Occupational Health, the HR Department and other specialist advisers as necessary. Further developments are anticipated following the establishment of a staff disability network.

Regular communication takes place to provide employees systematically with information on matters of concern and interest to them. Examples of this are through the publication of weekly headlines and The View. A monthly brief is cascaded from the Extended Executive Management Team to all staff and available to download from the intranet. Other avenues include local and Trust Partnership forums attended by management, staff representatives/trade unions. Furthermore there are specific ad-hoc staff briefings as appropriate via informal and formal consultation structures (as described in the organisational change policy).

The Trust has an anti-fraud, bribery and corruption policy which is available to all staff on the Trust's intranet and is supplemented by counter fraud awareness sessions and communications.

The Trust takes Health & Safety very seriously and ensures there is regular communication and information on this subject. The Health & Safety Trust Action Group receives regular information on Health & Safety performance. There is also regular reporting to the Clinical Governance & Clinical Safety Committee. In addition there is an annual Health & Safety report presented to the Executive Management Team and Clinical Governance and Clinical Safety Committee as well as the Trust Board.

Freedom to Speak Up

The Trust has always recognised the importance of creating an organisational culture where staff feels able and safe to raise concerns at work including malpractice, service user and staff safety issues, harassment and bullying and fraud. To support this, the Trust established a network of Freedom to Speak Up Guardians.

The Freedom to Speak Up Guardians network initially comprised of Staff Governors. The membership was extended to representatives from the Staff Equality Networks and in 2018 one day a week dedicated time was agreed for one of the Guardians. This dedicated time has clearly had a significant impact and enabled the Freedom to Speak Up Guardian (FSUG) role and function to develop over the past 12 months. Whilst the dedicated time has brought real benefits it was felt to continue to progress this key agenda additional time is required to maximise the role and function. A business case was approved by the EMT for a half time secondment to a FSUG lead post and this is in the process of being recruited too.

The FSUGs presented their annual report to the Clinical Governance and Clinical Safety Committee in April 2019. The report covered the following:

- The nature of cases
- Details of any patient/service related cases
- Network issues

The network reported that the FSUG have had a total of 14 cases raised with them in 2018/19. The dedicated time has enabled more proactive work to be undertaken by the FSUGs.

Trade Union Facility Time

Trade union facility time reporting 2018/2019

The trade union (facility time publication requirements) regulations 2017 came in to force in April 2017. In line with the regulations, all employers must publish information on facility time, which is agreed time off from an individual's job to carry out a trade union role, before 31 July.

South West Yorkshire Partnership NHS Foundation Trust's facility time publication for 2018/19 can be found below.

Table 1 - Relevant union officials

This table represents the total number of employees who were relevant union officials during the year.

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
34	3,657

Table 2 - Percentage of time spent on facility time

This table highlights for the employees who were relevant union officials employed during the relevant period what proportion of their working hours was spent on facility time

Percentage of time	*Number of employees*
0%	2
1-50%	29
51%-99%	0
100%	3

Table 3 - Percentage of pay bill spent on facility time
This table highlights the percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	£000s
Provide the total cost of facility time	£159
Provide the total pay bill	£157,221
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.1%

Paid trade union activities

As a percentage of total paid facility time hours for employees who were relevant union officials during the relevant period 12% was spent on paid trade union activities.

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 2019 and any new arrangements entered into in 2018/19. 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 2019 for more than £245 per day and that last longer than six months	
Number of existing engagements as of 31 March 2019	24
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	 9 7 2 1 5
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 2018 and 31 March 2019 for more than £245 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 2018 and 31 March 2019	27
Of Which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	27
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review -	0

TABLE 3: For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019	
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.	19
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: 23 May 2019

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. 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.

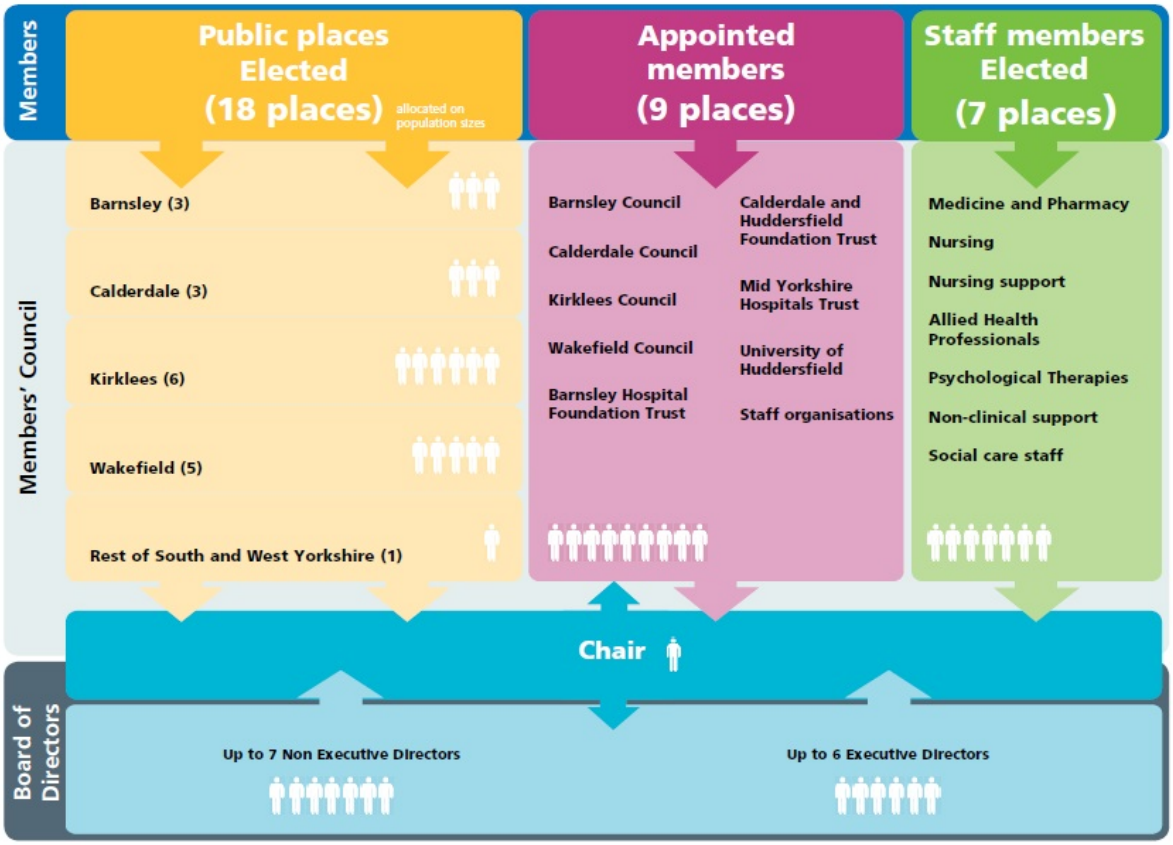
Our Members' Council

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 Trust's website.

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



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.

Jackie Craven was appointed as Lead Governor by the Members' Council in July 2017, following a recommendation from the Nominations Committee, for a period of two years.

Our governors

The table below sets out the governors in place as at 31 March 2019:

Name/representing	Term of office	Members' Council attendance 2018/19
Lead Governor		
Jackie Craven Elected – public Wakefield	1 May 2014 for three years Re-elected 1 May 2017 for three years	4/4
Governors		
Marios Adamou Elected – staff medicine and pharmacy	1 May 2012 for three years Re-elected 1 May 2015 for three years	3/4

Name/representing	Term of office	Members' Council attendance 2018/19
	Re-elected 1 May 2018 for three years	
Neil Alexander Elected – public Calderdale	1 May 2017 for three years	3/4
Kate Amaral Elected – public Wakefield	1 May 2018 for three years	1/3
Bill Barkworth Elected – public Barnsley	1 May 2017 for three years	2/4
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	1/4
Adrian Deakin Elected – staff nursing	1 May 2012 for three years Re-elected 1 May 2015 for three years Re-elected 1 May 2018 for three years	3/4
Daz Dooler Elected – public Wakefield	1 May 2018 for three years	2/3
Stefanie Hampson Appointed – Staff side organisations	24 February 2016 for three years	3/4
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	3/4
Faith Heptinstall Appointed – Wakefield Council	3 October 2019 for three years	2/2
Lisa Hogarth Elected – staff allied health professionals	1 May 2018 for three years	2/3
Carol Irving Elected – public Kirklees	1 May 2016 for three years	3/4
Tariq Khan (Shaun Adam) Elected – public Barnsley	1 May 2016 for three years	0/4
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	2/4
Debbie Newton Appointed – Mid-Yorkshire Hospitals NHS Trust	1 November 2019 for three years	2/2
Chris Pillai Appointed – Calderdale Council	8 June 2016 for three years	2/4
Caroline Saunders Appointed – Barnsley Council	8 June 2016 for three years	1/4
Phil Shire Elected – public Calderdale	1 May 2016 for three years	3/4
Jeremy Smith Elected – public Kirklees	1 May 2016 for three years	3/4

Name/representing	Term of office	Members' Council attendance 2018/19
Richard Smith Appointed – Kirklees Council	2 June 2016 for three years	0/4
Barry Tolchard Appointed - University of Huddersfield	1 April 2018 for three years	1/1
Debby Walker Elected – staff non-clinical support	1 May 2018 for three years	2/3
Mike Walker Elected – public Kirklees	1 May 2018 for three years	0/3
Paul Williams Rest of South and West Yorkshire	1 May 2018 for three years	1/3
Gemma Wilson Elected – staff nursing support	1 May 2016 for three years	1/4
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	1/4

The following governors left the Members' Council during 2018/19:

Name/representing	Term of office ended/reason
Claire Girvan Elected – staff allied health professionals	30 April 2018 Was not re-elected.
John Haworth Elected – staff non-clinical support	30 April 2018 Did not stand for re-election.
David Jones Appointed – Wakefield Council	16 April 2018 Resigned due to portfolio changes at the Council.
Jules Preston Appointed – Mid-Yorkshire Hospitals NHS Trust	31 October 2018 Resigned.

During 2018/19, the following governor sadly passed away:

Name/representing	Term of office ended
Tina Harrison Elected – public Kirklees	April 2018

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 2018/19 was £788 to 10 governors (against a total in 2017/18 was £1,321.60).

The election process for the Members' Council began in February 2019 for the following seats:

Public

- Barnsley – 1 seat
- Calderdale – 2 seats

- Kirklees – 4 seats
- Wakefield – 1 seat

Staff
- Nursing support – 1 seat
- Social care staff in integrated teams – 1 seat

The nominations process ended on 1 March 2019 and the following were elected unopposed:

Public
- Barnsley – Keith Stuart-Clarke
- Calderdale – Adam Jhugroo, Phil Shire (re-elected)

Staff
- Social care staff in integrated teams – Paul Batty

An election was held for the remaining seats, the election process opened on the 25 March 2019 and closed on the 18 April 2019. The following were elected:

Public
- Kirklees (4 seats) - John Laville, Carol Irving (re-elected), Jeremy Smith (re-elected), Hannah Jackson
- Wakefield (1 seat) - Bob Clayden (re-elected)

Staff
- Nursing support - Debs Teale

There are currently no seats vacant on our Members' Council.

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.

The Chair ensures that the views of governors and members are communicated to the board as a whole. A joint meeting is held annually between Trust Board and the Members' Council to specifically look at the Trust's forward strategy. At the meeting in November 2018, 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 Trust's strategic direction. The contribution from governors has informed and contributed to development of the Trust's annual planning for 2019/20. This joint meeting, along with the Trust Board's attendance at Members' Council meetings enables the directors to develop an understanding of the views of governors and members.

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 2019/20 (joint meeting with Trust Board) in November 2018.

Statutory duties

- Appointment and re-appointment of Non-Executive Directors.
- Review of the Chair and Non-Executive Directors' remuneration.
- Received the Annual Report and accounts.

Trust activity

- Engagement on Trust strategy and priority programmes.
- Attendance at Members' Council groups.

Personal development

- Annual evaluation of the contribution of the Members' Council and governors both individually and collectively.
- Attendance at the NHS Providers GovernWell training and development modules along with internal development sessions.
- Attendance at regional governors' meetings.
- Attendance at NHS Providers Annual Governor Conference.

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 undertake cleansing annually to assist with the accuracy of information on our membership data base. As at 31 March 2019, we had 9,137 public members (9,318 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. An update on how representative the membership is and the level and effectiveness of member engagement is provided annually at the Trusts' Annual Members' Meeting. 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;
- continued implementation of Membership Strategy action plan;
- on-going development of our governors to reflect governor feedback following development sessions;
- input to priority programme and integrated care system work streams to shape future services to ensure they are fit for purpose; and
- supporting staff governors who wish to be Freedom to Speak up guardians.

This approach is supported by our vision for volunteering through our members. At 31 March 2019, we have 260 volunteers within the Trust which equates to 2,847 hours per month, and 34,164 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.

In accordance with our Constitution, 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 2019, we had 3,619 staff members (4,193 in 2017/18).

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 segment 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 2019. 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**	**2018/19**				**2017/18**	
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	1	1	2	3	1	1
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	2	2	3	4	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	1
	Agency spend	2	2	2	1	2	1
Overall scoring		1	1	1	2	3	**1**

The overall risk rating for finance and use of resources is 1, which is a positive result for 2018/19. The plan is to achieve a similar performance and same rating for 2019/20.

Section 2.6 Voluntary disclosures

Equality reporting

Our Equality Annual 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 Equality Annual Report to Trust Board in July 2018 on the Trusts website and under the social, community anti-bribery and human rights issues section of this report (see page 33).

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.
- We have policies in place which 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.

Our anti-slavery programme also:

- supports 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.
- ensures 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
- ensures 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 33).

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: 23 May 2019

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.

- 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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: 23 May 2019

Annual Governance Statement 2018/19

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 2019 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 continuity in the Executive Director team. There have been some changes in posts, with a reduction in the number of Business Delivery Unit (BDU) directors to consolidate all operational matters under a single Director of Operations. A Director of Provider Development has been created to support the substantial changes

occurring across West Yorkshire & Harrogate. These changes reflect the fact that 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 & Bassetlaw and West Yorkshire & Harrogate. 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 continued to operate a strengthened risk management arrangement during 2018/19 with regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its 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 biennially. 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 and is due to be reviewed again in April 2019.

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 30 April 2019.

The Audit Committee assessment was supported by the Trust internal auditors who conducted a survey of Trust Board members for the second consecutive year 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. It was further refined during 2018. 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 2018/19, further work has continued to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

Risk exception reports are used at the relevant committees or fora of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work continues to take place to further develop risk tolerance and this is a regular item of discussion at Trust Board meetings.

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. At the February strategy meeting of the Board the structure of the BAF was reviewed to assess whether it was sufficiently capturing strategic risks. Some revisions were suggested which will strengthen the focus on strategic workforce risks particularly. The Board will approve the outline of the updated BAF in April 2019.

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 2018/19, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director. My objectives were discussed and agreed with the Chair.

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 2018/19 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, development of new roles and establishment reviews Development of staff networks
Acuity and demand pressures	Successfully implemented waiting list initiatives, with more underway. Extra focus on hotspots such as CAMHS and inpatient wards. System-wide reviews Continued focus on serious incident reporting, investigations & learning. Greater partnership working with local partners. Ongoing review with commissioners
Financial sustainability in a changing environment	Financial sustainability plan being developed Maintaining focus on quality improvement. Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems
Out of area placements	High level of internal focus Engagement of independent support and implementation of recommendations Working closely with commissioners to identify system wide solutions
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.
Tenders and operating environment	Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems Engagement in all places the Trust operates in Stakeholder engagement plans

Given the strategic context within which we operate, the risks outlined above will continue into 2019/20 with mitigating actions in place. The creation of Integrated Care Systems (ICS) across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the ICS in West Yorkshire & Harrogate, I am able to ensure we are closely engaged in the leadership and delivery of these plans. The Director of Provider Development role means we have senior capacity working on the programmes that relate to the Trust. In parallel, as an engaged member of the leadership team of the South Yorkshire & Bassetlaw ICS, I will ensure that the risks inherent in the move to an Integrated Care

System are understood and mitigated. The Board has kept my dual role, as Chief Executive of SWYPFT and lead Chief Executive of the West Yorkshire & Harrogate ICS, under regular review to ensure the arrangement continues to work in the interests of the Trust as well as the ICS.

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 Trust recorded a deficit in 2018/19 prior to the provision of provider sustainability funding. Achievement of our underlying deficit plan resulted in provider sustainability funding of £4.7m being achieved and as such a net surplus is recorded prior to the impact of asset revaluations

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 quality monitoring 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 'Requires Improvement' overall by the CQC. This includes ratings of Good for, Caring, Effectiveness and for being Well-Led. Eleven out of fourteen core service lines are rated 'Good' overall with community based mental health services for adult of working age, specialist community mental health services for children and young people, and acute wards for adults of working age & psychiatric intensive care units being rated as 'Requires Improvement'.

Our ratings chart shows that 86% of the ratings within our service lines were found to be 'Good' or 'Outstanding'. The CQC found that 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 2018 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.

Values 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.

This has been further strengthened in 2018/19 with changes to the appraisal system to focus on objectives and values more explicitly.

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 2018/19, 12,640 incidents were reported, of which 88% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based and good reporting 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. Following the latest Well Led Review by the CQC, the Trust joined the inaugural Mental Health Safety improvement Partnership between the CQC and NHS Improvement. This work looks at balancing the requirements of our regulators on quality and finance with the need to improve services and true value.

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 2018/19, there were 45 serious incidents across the Trust compared to 71 in 2017/18. 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 a regular report to the Operational Management Group, the Executive Management Team and reported through the governance structures to Board. There was one duty of candour breach in the year.

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. This includes a review of arrangements for managing waiting lists for Child and Adolescent Mental Health

Services (CAMHS), and a recent report on improving the quality of the mortality review process. The Committee routinely monitors infection, prevention and control management of violence, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drugs and therapeutic committee. 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.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. Trust Board also receives a quarterly report on complaints through a customer service report.
- 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, Reducing Restrictive Practice Group, Drugs and Therapeutics and policy development.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing & Quality 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 areas within the statement.
- The Freedom to Speak Up Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The staff has four Guardians, drawn from the staff governors and a representative of the BAME network. The arrangements surrounding the Guardians have been

strengthened, with a slot at new staff induction, better administrative support, protected time allocated and clearer guidance available.

- The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensure that its obligations under the Climate Change Act and the Adaptation

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. The new mental health clinical record system implementation approach ensured that staff were fully engaged during both design and delivery phases.
- 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 with an improved rating in the accreditation process for this year.

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 the implementation of our patient safety strategy and the development of an integrated approach to quality improvement that equips our staff to make improvements for the benefits of our service users and carers..*
- *Operational excellence - focuses on improving patient flow through our systems and making the best use of all our resources including the use of technology to improve clinical care and our productivity through agile working and the implementation of the 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. The Trust Board has 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 networks are a significant part of our approach. The Black, Asian and minority ethnic (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. The Network had its second annual celebration event, which showcased some of their achievements, in October 2018. The Trust has also established a disability staff equality network and a Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) network using the same principles of self-determination and support. The networks play an active role in a number of elements of Trust business, including recruitment to senior positions and the development of Freedom to Speak Up Guardians.

The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on BAME Staff. The clinical network was established as in the NHS Staff Survey BAME staff reported the highest level of bullying and harassment from services users and carers.

Over the last year, the Board has continued to become more diverse. Appointments at director and non-executive director level have meant a better gender, age and ethnic balance across the Board.

In 2018/19, the Equality and Inclusion Forum received reports on the following:

- *Wellbeing survey results.*

- *Progress against the Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) reports and action plans*
- *Equality Delivery System (EDS2) report and action plan*
- *The Trust's equality, inclusion and engagement review*
- *Our inclusive leadership and development programmes.*

The Trust has improved in 3 of the 4 Workforce Race Equality Standard indicators published in the NHS Staff Survey.

During the year, the Trust published its gender pay gap audit as required by law, and in addition produced pay gap audits for ethnicity and disability. These showed there is a pay gap on both gender and ethnicity but not disability. An action plan has been agreed and published on the Trust's internet.

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.

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 at 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 successor Integrated Care Systems) 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 the Director of Operations, BDU Deputy 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 revised financial control total of £2.0m deficit by achieving a deficit of £1.6m. This entitled us to receive Provider Sustainability Funding (PSF) of £4.7m. There are various levels of surplus and deficit and the following table provides a reconciliation between the comprehensive expense of £23.4m as shown in our accounts and the £1.6m deficit quoted above:

	£m
Total Comprehensive Income/(Expense)	(23.4)
Impairments and Revaluations	14.7
Net Impairments	11.9
Provider Sustainability Funding (PSF)	(4.7)
Pre PSF Surplus in our management accounts	(1.6)

In total, £10.6m cost savings were delivered against a target of £9.7m (109% delivery). Of the £10.6m, £7.9m was delivered recurrently and a further £2.7m 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 2019.*

Information governance has had continued focus through 2018/19 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. The Audit Committee reviewed progress against all actions; the vast majority of which were completed in 2017/18 with final completion of outstanding actions taking place in early 2018/19. A deep dive of causes of confidentiality breaches was undertaken and reviewed at the Audit Committee in April 2019.

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 2 such incidents reported in 2018/19. This is a reduction compared to the nine reported incidents in 2016/17 and four incidents in 2017/18. They are summarised below together with the actions taken:

- A laptop and diary containing sensitive personal data was stolen from a staff member's car
- Hand written bed management information including patient details was stolen from a ward by a service user

No further action has been taken by the ICO in respect of these incidents.

Good information governance will continue to be a feature of the Trust in 2019/20. The Data Security and Protection Toolkit was submitted that is compliant with the standards.

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 Report 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 oversee 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.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with input from ICIG and with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- 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.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- 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.
- During the move to a new clinical record system, staff training has been a key consideration of readiness for movement to the next implementation phase of the system. Training in the use of SystmOne for mental health reached levels of 89% registered staff, 88% front line staff and 80% all staff prior to going live and in line with requirements set by the Trust.

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. Internal Audit conducted two reviews of the governance and programme management arrangements of the implementation of the clinical record system. Any recommendations were taken account of and factored into our implementation plans.

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 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. My appraisal is undertaken by the Chair. Non-Executive Director appraisals are undertaken by the Chair of the Trust. The Non-Executives' performance is collectively reviewed by the Members' Council. The appraisal of the Chair is led by the Senior Independent Director and reports to the Members' Council on the outcome.

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. During 2018/19, approximately 98% of staff had an appraisal.

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 2018/19 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.

In respect of the internal audit plan for 2018/19, 11 internal audit reviews have been presented to the Audit Committee. Of these, there were 9 significant assurance opinions and 2 limited assurance opinions in relation to complaints management and phase 1 of the programme management arrangements relating to the implementation of the clinical record system. It should be noted phase 2 of this audit conducted closer to go-live provided significant assurance.

The fieldwork for the three remaining reports from the 2018/19 plan relating to Cost Improvement Projects & transformation, Data Quality framework and Compliance with legislation are in progress with the assurance ratings subject to discussion 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 2018/19 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: 23 May 2019

South West Yorkshire Partnership NHS Foundation Trust

Quality account | 2018/19

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 is our mission as an organisation. This Quality Account sets out how we have done this, guided by our strong set of values which are embedded throughout the Trust in the people that work across our services. Our people constitute our greatest investment and our greatest resource.

Delivering our mission requires a focus on finance and quality and we welcome the opportunity to publish our Quality Account alongside our Annual Accounts. Quality is what matters most to people who use services and what motivates and unites everyone working in health and care services. 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.

Throughout the year, we have put safety first, always. Where incidents or service issues have arisen, we have addressed them openly, honestly and with a view to improvement. This is essential in challenging times and we have then continued to achieve the majority of our service and financial targets and deliver care to some of the most vulnerable people in society.

We were caring
In March and April we welcomed the CQC's independent view of our Trust following their inspection. Our report was published in July and highlighted areas of strength and improvement, as well as areas of real challenge. 11 of our 14 core services were rated Good – and all of them were rated Good for being caring. We're proud that more than 85% of individual domains across our services were rated Good or Outstanding (60 out of 70).

This meant a CQC rating overall that was Good for being "well-led", "caring" and "effective". Issues in a small number of services meant we were rated requires improvement for "safety", leading to action to address the issues raised and a focus of the Board on redress. Continuing long waits in some service, notably our child and adolescent mental health services (CAMHS), and our of area placements in our inpatient units meant a rating Requires Improvement in the "responsive" domain. These issues in 15% of our domains meant an overall rating of Requires Improvement as a Trust.

We were disappointed to see our overall rating go down and have worked to address this subsequently, being well set for our review in June 2019. We also note that an overall rating should not obscure areas that have improved, for example Learning Disability services, or examples of good practice identified in the report.

We achieved the majority of our key targets
We achieved the majority of targets set by our regulators and commissioners, including access to key services.

- IAPT (Improving Access to Psychological Therapies) moving to recovery for the period April – March - 53.0%
- Proportion of people waiting 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment - 92.3%
- Proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment - 99.5%
- 99.5% of people were seen within 6 weeks for diagnostic procedures
- 99.4% of referrals had a waiting time for treatment of less than 18 weeks as at end March 19

- 87.3% of people experiencing a first episode of psychosis were treated within two weeks of referral
- 97.5% of patients on care programme approach who were followed up within seven days
- 97.7% percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper
- 94.6% service uses in crisis assessed within 4 hours
- 76.9% routine referrals assessed within 14 days of referral
- 76% of staff vaccinated against flu

We also achieved our own internally-set targets, including:

- 85% of staff trained in the Mental Health Act
- 92% of staff trained in the Mental Capacity Act.

Alongside these successes, we continued to focus on improving performance in specific services. Too many people go out of area for acute mental health treatment and our CAMHS waiting times must improve.

We embraced change and tackled challenges

- We launched a new clinical record system, SystmOne. Replacing our previous clinical records system has been undertaken with staff across the Trust over a sustained period. The new system will be more fit for purpose, easier to use, and more efficient.
- Our new adult acute mental health centre at Fieldhead in Wakefield was completed in summer 2018 following £17m of investment in mental health services. The Unity Centre has been purpose-built and incorporates three wards which are now accredited by the Royal College of Psychiatrists.
- Some of our services have seen significant changes with decommissioning, new contracts and models of care. Throughout this, we have worked to ensure that our staff are supported and transitions are well managed
- 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.

Examples of our participation include our support and input for the successful implementation of *new care models* in West Yorkshire for CAMHS, and the establishment of community teams for eating disorder services. In forensic services we have led the West Yorkshire forensic providers group, and are preparing a business case on behalf of the group (working with NHS England) for a *new care model* for forensic services in West Yorkshire.

In Wakefield the Trust leads a Mental Health Provider Alliance, bringing together all providers of mental health services. The Alliance was able to support winter pressures in the Wakefield system by the innovative use of a £200k grant from Wakefield Council. It is now the vehicle for planning for mental health services across Wakefield.

We managed staff pressures and financial challenges

We have continued to manage service delivery within a national context of staffing shortages and financial pressure. This has been most acutely felt in our medical staffing, with junior doctor rota gaps and consultant posts covered by locums, and nursing vacancies. To tackle this, we have:

- Focused on recruitment and retention with support from NHS Improvement seeing turnover overall fall from 14.85% in 2017-18 to 12.82% in 2018-19. Notably, turnover in clinical support workforce roles has significantly reduced in the past 12 months from 18.1% to 10.7% due to effective career pathway opportunity improving retention.

- Managed sickness and wellbeing with targeted interventions for all staff and a nationally-recognised campaign, #allofus
- Ensure safer staffing remained a priority in inpatient services, achieving our safer staffing levels with appropriate escalation of hotspots
- Ensured good use of high quality temporary staffing
- Strengthened our values based recruitment, induction and appraisal

We achieved the financial targets set by our regulators, delivering a deficit of £1.6m (against an initial control total of £2.6m deficit) prior to Provider Sustainability Funding (PSF) and a surplus of £3.1m after our PSF was allocated. This required cost improvements of £10.6m to be delivered.

Our strategic priorities for 2019/20
In the coming year we want to continue to build on our successes and learn from our challenges to deliver our priorities. This means we will:

- Improve health so that we deliver our role in integrated care in every place we operate
- Improve care with our reports or ratings in every service visited by the CQC
- Deliver our financial targets with improved use of resources
- Make the Trust a great place to work

Our key objectives include:

- Work with our partners to join up care in each of our communities, including through new primary care networks
- Improve our mental health offer for older people
- Advance our wellbeing and recovery approach reflecting a national drive towards social prescribing and holistic care
- Provide safe care every time and in every service
- Provide all care as close to home as possible, reducing out of area placements
- Make care quickly and easily available, to reduce waiting times especially in CAMHS and Autism
- Embed our quality improvement methodology #allofusimprove to enhance quality
- Spend money wisely and reduce waste to drive efficiency
- Make the most of our clinical information systems to support safety and efficiency
- Make better use of digital technology to support all aspects of quality
- Support the wellbeing of our staff through and enhancement of our programme #allofus
- Have better conversations with all of our people to ensure an engaged model of leadership in practice
- That we will not tolerate bullying and harassment and will move to make South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) a place at the forefront of tackling this issue.

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 and Governors have 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: 23 May 2019

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 2018/19' (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 be outstanding.

Our approach to quality improvement

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

Our visions, mission and values

We exist to help people reach their potential and live well in their community. Our mission is to provide outstanding physical, mental and social care in a modern health and care system. 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 our services and what motivates and unites everyone working in health and care services. The Trust's quality strategy 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

Safe: 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 2018/19 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 were identified for Year 1 have been monitored as part of the quality account process for 2018-19 and are reported on in Part 3 of this report. The remaining projects have been identified as priorities for forthcoming quality account reports.

Our executive lead for quality improvement is the Director of Nursing and Quality. Our Trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values. These embed the drive to 'improve and be outstanding' enshrined in our values.

Our approach to quality governance

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 have focused 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 has matured, which supports every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

We have developed a quality assurance and improvement 'self- governing' assessment model, which provides a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model provides 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 be a continual source of evidence for teams to inform them how well they are performing against quality standards.

The aim is to foster each team's sense of responsibility for its own quality outcomes and engender optimism that the quality of service delivery can continually be improved. As part of this initiative we have developed 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.

To guide our development we report on over 20 different quality indicators in our integrated performance report (IPR), including friends and family test results, infection prevention, serious incidents, safer staffing, pressure ulcers, commissioning quality 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. The report is considered at the executive management team, the Board and its Committees. This enables us to be responsive when issues to quality arise and evidence the return on our investment in quality. An example of this is restraint data.

From scrutinising our performance information we identified a quality issue with restraints. In response we:

- Undertook a thorough review of the data
- Analysed all information we held on restraint (other than performance information, e.g. incident data and CQC insight data)
- Identified the area where restraints were high, i.e. Nostell ward
- Reported findings into our Clinical Governance and Clinical safety Committee (CGCSC)
- Developed a programme of work to support staff in managing issues that were impacting on practice, and
- Engaged with NHSI in a quality improvement programme to reduce restraint, seclusion and rapid tranquilisation.

Early indications are that this work is impacting positively on care and experience of service users. Details of the project outcomes will be reported as a #allofusimprove improvement project in our 2019/20 Quality Account report.

We learn through a robust clinical audit programme and we participate in research and development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives including the national confidential enquiry into homicide and suicide, mental health benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to all our operational areas, from which we derive significant learning and quality assurance.

We are engaged in a cycle of delivering against our improvement plans following Care Quality Commission (CQC) inspections, which is focused upon actions that are already underway and actions arising from new insights the CQC brings. We remain committed to ensuring that compliance is achieved through a focus on improvement.

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

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. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Strategy. The functions of the group are: horizon and risk scanning; interpretation and reporting of national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; planning and monitoring delivery against plan. We also have a Members Council Quality Group to support the Trust in its approach to 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 2018/19

Throughout 2018/19 we measured activity against each of our quality priorities and reported them to our Clinical Governance and Clinical Safety Committee, Members Council Quality group, and through the Integrated Performance Report (IPR). Our progress against these priorities can be found in 'Part 3 – Our Performance in 2018/19'. Below is a summary of our performance against 2018/19 quality priorities:

	No. of priorities	RAG rated summary of performance
Safe	5	5 rated green, 0 rated amber, 0 rated red
Effective	5	4 rated green, 1 rated amber, 0 rated red
Caring	5	4 rated green, 1 rated amber, 0 rated red
Responsive	2	2 rated green, 0 rated amber, 0 rated red
Well Led	2	2 rated green, 0 rated amber, 0 rated red
Total	**19**	**17 rated green, 2 rated amber, 0 rated red,**
Key: Green – achieved 90% plus of goals in set timescale; Amber – progress is being made, out of timescale; red- not achieving goals set.		

We have achieved 89.5% of the goals we set for ourselves, came within 10.5% of achieving the remaining goals. The full details of our performance can be found on pages 36-37.

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.

Description of risk to quality	Impact	Mitigating actions
Difficulties in recruiting qualified clinical staff due to national shortages.	Difficulties in ensuring optimal and safe staffing levels on mental health wards Lack of learning disability (LD) nurses, in particular newly qualified availability leading to extended vacancies in LD and child and adolescent mental health services (CAMHS). Medical staff recruitment.	Established strong links with the universities' undergraduate and masters programmes for nursing Introduction of nursing associate and associate practitioners Think Ahead programme for social workers in mental health Trust-wide retention plan Recruitment programme for newly qualified registered nurses Enhanced payments for registered nurses working on our bank

Description of risk to quality	Impact	Mitigating actions
		Relocation package for out of area nurse recruitment Engagement with current consultants on developing new service models and introducing new roles Flexibility in special interests for new consultant posts to make them more attractive Attractive reward packages in line with national terms and conditions Exploring potential for overseas recruitment
Increased activity and demand impacting on capacity and workforce.	Increased use of out of area placements Waiting times for psychological therapy and access to treatment in CAMHS Pressure on workforce	Out of area project established with commissioner support to improve flow, discharge and community-based support offer, thus reducing demand for out of area placements. Protocol established to risk scan patients on waiting list and offer appropriate support. Close working with commissioners to review demand and capacity position leading to revised investment plans in order to reduce waiting times across services. West Yorkshire and Harrogate systems work on managing capacity across the system for mental health, CAMHS and LD.
Sub-optimal transition to new mental health clinical record system.	Unfamiliar system leads to reduction in productivity beyond transition phase	Clinical records system project board established to govern system transition and optimisation programme. Data migration testing took place prior to “go live” Internal audit review conducted at key stages in implementation programme. Staff training plan developed and implemented prior to “go live” with key performance indicators (KPI) for required training levels. Super users trained to support staff at local level, video clip and written guidance available via intranet. Routine project reporting into Board, Audit Committee and Clinical Governance and Clinical Safety Committee.

Quality priorities 2019-20

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE and 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.

Below is a list of quality priorities that the Trust identified in our quality strategy 2018-21.

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 2018-21.

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
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 care hours per patient day (CHPPD) analysis of staffing figures Review staffing in the mental health community teams with a view to developing a community staffing tool	Trust-wide inpatient areas and community teams	Project plan developed and 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 2020**
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs,	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	Key patient safety projects 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**

both personal and financial associated with patient safety incidents	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 plan	Trust-wide services	Progress against planned objectives monitored by the suicide prevention group	Reduction in suicides by 10% across the population serviced by SWYPT.	**March 2022**

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 and procedures Review of governance process to support policy and 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 and procedures governance process	**October 2019** (extended from 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 Trust wide level Development of systems and processes to support implementation	Trust-wide services	Project plan to be developed Monitored by executive management team (EMT)	Identification of outcomes measures for local and Trust wide implementation Reportable outcomes measures Ability to monitor clinical variation	**March 2020**
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 audit and quality monitoring Improving co-production Capturing service users ethnicity	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.

CARING: we will involve and treat people with compassion, dignity and respect -*Quality domain – Clinical experience*

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staff experience and well being	Monitor and implement actions of staff health and well- being plan 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 2020**

Patient experience	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 2020**
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 Fewer re opened complaints Monitor length of time from complaint to response < 40 days	**March 2020**
Allied health professionals (AHP) strategy: Into action	Develop an updated AHP strategy that aligns with the Nursing strategy	Trust-wide allied health professionals	Monitor progress against objectives/ KPI's Monitored by AHP network	Revised nursing and AHP strategy with clear objectives and targets.	**September 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 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 and inclusion (E and I) 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 and 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**
Care closer to home	Reduce the number of days people spend in out of area placements	Inpatient areas	Out of area bed reduction is a priority programme and will be monitored by EMT	Reduction in number of days people spend in out of area placements	**March 2020**

WELL LED: we will work in partnership and learn from our mistakes - *Quality domain – Safe, effective and 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.	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 clinical services	Assessment against a project plan. Key milestones will be identified and monitored.	A dashboard will be available for staff	**March 2021**
Safety first on acute wards : improvement initiatives using quality improvement techniques, focussed on safety	Establish a programme of quality improvement initiatives	Acute wards for adults and psychiatric intensive care units	Assessment against a project plan. Key milestones will be identified and monitored.	Successful implementation of quality projects.	**March 2021**

The measures identified in the Quality Priorities 2019/20 (above) will be reported and monitored in the following ways throughout the year:

1. Bi-monthly reporting of quality account measures into the Clinical Governance and Clinical Safety Committee.
2. Reporting into Clinical Governance Group (CGG)
3. Clinical Commissioning Groups via Quality Board meetings.

Care Quality Commission (CQC) inspection 2018

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 on-going complaints and serious incidents.

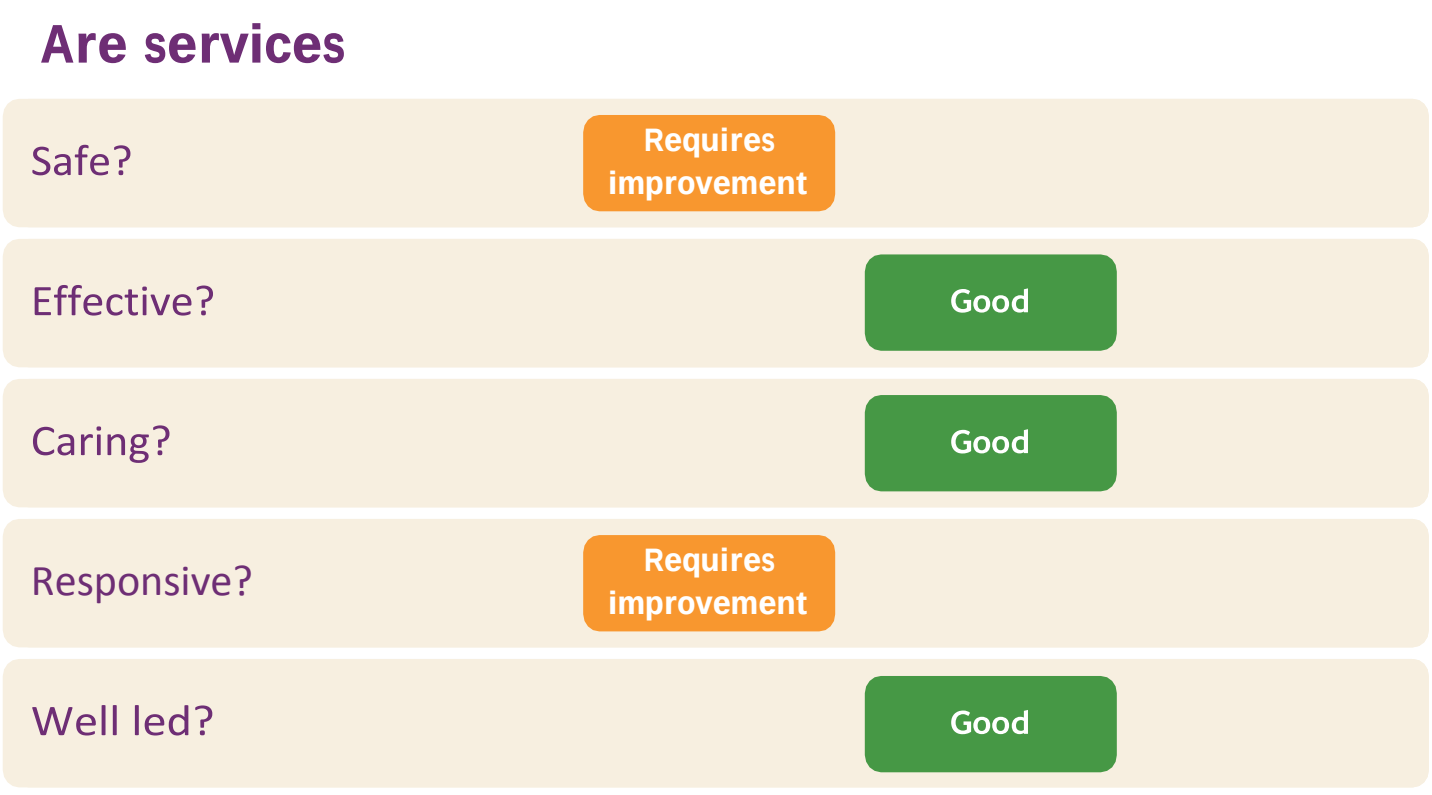
The outcome of the inspection was that our overall rating changed from Good to Requires Improvement. The CQC highlighted areas of strength and improvement, as well as areas of real challenge

- 11 of 14 core services are rated Good – and all rated Good for being caring
- More than 85% of individual domains rated Good or Outstanding (60 out of 70)
- Overall, we're rated Good for well-led, caring and effective domains, and Requires Improvement for safe and responsive domains

We addressed safety issues first and foremost and responded in line with our values. Our ratings can be found on the subsequent pages.

SWYPFT CQC ratings charts - April 2018

Our existing ratings are on display and our website.



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

	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	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
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	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

When the CQC visited our wards in March 2018 we received an 'inadequate' rating for safety on our acute wards for adults of working age and psychiatric intensive care units. We were disappointed by this rating as we do not believe it reflects the hard work, caring attitude and commitment to quality that our staff demonstrate on a day to day basis.

From the inspection visit we received **10 Must do** actions and 11 **Should do** actions. We have taken action against reviewed our practice against all these actions.

The CQC said we MUST review how our staff adhere to Trust policy in the following areas:

- Care and treatment of people in Seclusion
- Administration and documentation of rapid tranquilisation
- Safe management and recording of medicines
- Assess patients' risk at the intervals outlined in the trust policy
- Ensure our clinic room checks are carried out in line with Trust policies
- Section 17 leave forms in full and this reflects that patients and their carers understand their responsibilities and the requirements of the leave.

And, MUST also

- Ensure that patients have easy access to summon assistance from their bedrooms across all wards.
- Patients have sufficient access to therapeutic activity to meet their needs and support their recovery.
- Patient and carer involvement in care and discharge planning is accurately reflected in records.
- Have systems and processes in place to monitor the performance of the ward effectively and are used to improve the care and treatment provided.

Focus on reducing demand on acute wards:

One of the Trust priorities for 2018/19 was to reduce demand on the acute inpatient areas. A priority programme of work was undertaken which included work on the wards such as Criteria Led Discharge to reduce length of stay, as well as work with IHBT and community teams to manage people well at home and reduce the chance that they will need to be admitted. We have compared the systems in the different parts of the Trust and found good practice that we are sharing and areas where we will focus in the next phase.

This work is a very high priority for 2019/20. We have developed an evidenced based plan which aims to provide care closer to home and are now putting this into action. The six work streams identified are:

- Appropriate inpatient stays
    - Refining the criteria led discharge
    - Looking at what happens to our discharge rates when some senior medics go on leave
    - Having a consistent approach that keeps people as close to home as possible
- Effective gatekeeping of inpatient beds in Calderdale and Kirklees
- Reducing the number of people needing acute interventions in Calderdale and Kirklees
- Increasing income to address shortfalls
- Understanding, reporting and responding to data and information
- Enabling a strategic approach to deliver a low admission model – in particular this includes working with commissioners to look at the high numbers of referrals that are coming from some GPs and making sure that they have alternatives in place for people in their communities

Additional work to improve quality on acute wards:

- Trust wide Physical health strategy has been developed
- Cardio metabolic monitoring of people on acute wards
- Carer engagement
- Engaged with NHSI on Reducing Restrictive Practice Interventions quality improvement project on Nostell ward. (This programme will be rolled out across appropriate wards in SWYPFT)

- New approach to documenting and reviewing seclusion.

As these work streams begin to reduce demand on acute inpatient services, the ward sizes will be reviewed and where bed numbers can be reduced to improve quality and safety of care, we will do so.

Part 2.2 – Statements of assurance from the board

Review of services

During 2018/19 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 97 relevant health services. South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 97 (100%) of these services.

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2018/19.

Participation in clinical audit

During the 2018/19 nine (9) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2018/19 South West Yorkshire Partnership NHS Foundation Trust participated in 9/9 (100%) of the national clinical audits and 1/1 (100%) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SWYPFT was ***eligible to participate*** in, and ***did participate in*** during 2018/19 are as follows:

National Clinical Audits SWYPFT was eligible to participate in during 2018/19	1.POMH Topic 18a - Prescribing Clozapine 2.POMH Topic 6d - Assessment of the side effects of depot antipsychotics 3.National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit 4.Sentinel Stroke National Audit Programme (SSNAP) - clinical audit 5.National audit of end of life care (3 year cycle) 6.National Asthma and COPD audit programme NACAP re-audit 7.National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit 8.National Audit for Cardiac Rehabilitation 9.National Clinical Audit of Anxiety and Depression (NCAAD)
National Confidential Inquiries SWYPFT was eligible to participate in 2018/19	National Confidential Inquiry into Suicide and Homicide by people with mental illness

National clinical audit programme 2018/19

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 2018/19, 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
POMH Topic 18a - Prescribing Clozapine	264	POMH published report February 2018
POMH Topic 6d - Assessment of the side effects of depot antipsychotics	167	Awaiting national report
Sentinel Stroke National Audit Programme (SSNAP)	Awaiting national report	Awaiting national report
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit	250	All EIP spotlight data submitted to NCAP Nov 18, Indicator 3 of the Mental Health CQUIN to be submitted Feb 19 1/4/19 - 1st part complete - 2nd part in progress
National audit of end of life care (3 year cycle)	Organisational audit data submitted September 2018. Trust completion rate 97%	Audit summary, case note review and hospital survey are not applicable for mental health submissions
National Asthma and COPD audit programme NACAP re-audit	Registration completed for Pulmonary Rehabilitation Services August 2018	Audit timelines – November 2018 - Web tool pilot begins March 2019 - continuous clinical audit data input begins October - December 2020 - organisational audit data collection begins
National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit	52 submitted for case note audit	Awaiting service level reports
National Audit for Cardiac Rehabilitation	Registration completed for Cardiac Rehabilitation October 2018	Data collection commenced March 2019 continuous national audit
National Clinical Audit of Anxiety and Depression (NCAAD)	89	Awaiting final report

The reports of nine (9) national clinical audits were reviewed by the provider in 2018/19 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 that is responsible for presenting the audit results to their business delivery unit (BDU). 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 as part of their governance systems

National confidential inquiry (NCI) 2018/19

The national confidential inquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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	18	17 (94%)	1 questionnaire continues to be processed

Local clinical audit

During 2018/19 the Clinical Audit and Practice Evaluation (CAPE) prioritised plan had a total of 99 clinical audit projects listed. The reports of 40 local clinical audits were reviewed by the provider in 2018/19. There are 40 projects completed, 35 projects in progress and 24 projects have either been deferred into 2019/20 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 that 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 as part of their governance systems

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 2018-19 that were recruited during that period to participate in research approved by a research ethics committee: 354.

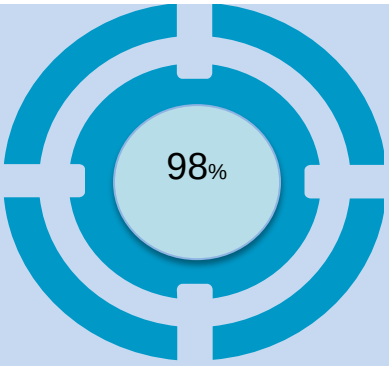
During the 2018-19 reporting period, 785 participants enrolled in a total of 31 Health Research Authority approved studies. 24 of these studies were approved by a Research Ethics Committee (not relevant to the remaining 7 studies). A total of 659 people took part in these 24 studies of which 354 were service users, 29 were carers and 137 were staff. The remaining 139 participants were a mix of staff, service users and carers and the exact breakdown is not available due to the anonymous nature of the data collection for these two studies.

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of income in 2018/19 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 2018/19 and for the following 12 month period are available electronically at www.swyt.nhs.uk/ performance reports.



The Trust met 98% of its CQUIN's in goals in 2018/19

An overall total of £4,330,832 was available for CQUIN to SWYPFT in 2018/19 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,194,832 (98%) is expected to be received for the associated payment.

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%) was received.

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 4 years SWYPFT has increased the percentage achievement for CQUIN's from 78% to 98%.

A summary of CQUIN achievement for 2018/19 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	£ 286,953	83%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£ 286,953	88%
		Improving Services for People with Mental Health needs who present to A and E	£ 286,953	100%
		Transitions out of Children and Young People's Mental Health Services	£ 286,953	98%
		Preventing Ill Health by Risky Behaviours - alcohol and tobacco	£ 286,953	100%
		ICS engagement	£ 956,511	100%
		TOTAL	**£2,391,278**	**96%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Secure services	**Low and medium secure services**	Adult Secure Mental Health Service Review	£284,825	100%
		Recovery Colleges for Medium and Low Secure Patients	£284,825	100%
		TOTAL	**£569,649**	**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	£158,072	83%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£126,487	88%
		Improving Services for People with Mental Health needs who present to A and E	£126,487	100%
		Transitions out of Children and Young People's Mental Health Services	£126,487	98%
		Preventing Ill Health by Risky Behaviours - alcohol and tobacco	£126,487	100%
		Improving the Assessment Of Wounds	£31,585	100%
		Personalised Care and Support Planning	£31,585	100%
		Patient self-administering of medication - Intermediate Care	£31,585	100%
		Patients at risk of re-admission - Intermediate Care	£31,585	100%
		#endpjparalysis - Intermediate Care	£31,585	100%
		ICS engagement	£547,962	100%
		TOTAL	**£1,369,905**	**97%**

*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.

South West Yorkshire Partnership NHS Foundation Trusts conditions of registration state that the three regulated activities listed above can only be carried out at the following locations:

- Fieldhead Hospital (Wakefield)
- The Dales (Calderdale Royal Hospital)
- Kendray Hospital (Barnsley)
- The Priestley Unit (Dewsbury District Hospital)
- Lyndhurst (Halifax)
- Enfield Down (Huddersfield)
- The Poplars (Hemsworth)

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2018/19

NHS Number and General Medical Practice Code Validity

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2018/19 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:

- 99.9% 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.

Data security and protection toolkit (previously Information Governance Toolkit attainment)

South West Yorkshire Partnership NHS Foundation Trust assessment was submitted on March 27th 2019 and our status is 'standards met'.

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 2018-19 on improving the quality of clinical record keeping (Three priority areas were identified and are being monitored on an ongoing basis – this is to be reviewed during 19/20 following 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 2019-20 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 2019-20 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 have just undertaken a large transformation programme to implement a new mental health clinical information system, the project will move to the optimisation stage and as part of this, we are working to ensure innovation for quality is embedded. We will also continue to 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%					
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	**2018/19**	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
		SWYPFT 2018/19	97.7%	96.2%	97.3%	99.6%*	97.5%
		NHS England (NHSE) data 2018/19	95.8%	95.7%	95.5%	95.8%	95.7%
		NHSE provider lowest performance (2018/19)	73,4%	83.0%	81.6%	83.5%	93.4%
		NHSE provider highest performance 2018/19	100%	100%	100%	100%	100%
		SWYPFT 2017/18	97.7%	95.5%	96.9%	97.2%	
		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 the Health and Social Care Information Centre.

Performance data is reviewed monthly by the executive management team and the Trust Board.

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

An Improving Clinical Information Group sponsored and chaired by the Director of Nursing and 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 scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

* *Following a change of clinical system, South West Yorkshire Partnership NHS Trust have experienced data quality issues. This impacted on the completeness of the Q4 data submitted. Further work has been undertaken and the final position for the Trust is 99.2% - this does not change performance only marginally reduces the nationally submitted figure.*

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					
		2018/19	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	2: Enhancing quality of life for people with long-term conditions	SWYPFT 2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		NHS England (NHSE) data 2018/19	98.1%	98.4%	97.8%	98.1%	98.1%
		NHSE provider lowest performance 2018/19	85.1%	81.4%	78.8%	88.2%	78.8%
		NHSE provider highest performance 2018/19	100%	100%	100%	100%	100%
		SWYPFT 2017/18	98.4%	96.9%	96.9%	99.6%	98%
		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.

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

Data is clinically validated before it is submitted to 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 and Quality, meets quarterly to ensure a focus on the quality of clinical data. Each business delivery unit has developed a robust process to improve the quality of their clinical data.
- We undertake a weekly audit of our gate kept admissions to validate the gate keeping function.
- Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

** Following a change of clinical system, South West Yorkshire Partnership NHS Trust have experienced data quality issues. This impacted on the completeness of the Q4 data submitted. Further work has been undertaken and the final position for the Trust is 96.8% - this does not change performance only marginally increases the nationally submitted figure.*

2.3.4 Readmission rates

Indicator	NHS Outcomes Framework Domain	SWYPFT data						
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
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	6.86%	7.02%	8.7%	9.7%	9.8%	9.8%	9.1%

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

90.9% of people were not readmitted.

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

This information is taken from the clinical record.

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

Data is clinically validated before it is submitted to 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 and Quality 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 scrutinise 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 2018 Score (out of 10)</th><th colspan="2">National 2018 score</th></tr>
<tr><td rowspan="19">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="19">2: Enhancing quality of life for people with long-term conditions

4: Ensuring that people have a positive experience of care</td><td>6.7</td><td colspan="2">National comparison

About the same as other trusts nationally

(CQC website)</td></tr>
<tr><td>SWYPFT 2017 Score (out of 10)</td><td colspan="2">National 2017 score
National comparison</td></tr>
<tr><td>7.9</td><td colspan="2">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 09.04.19, and it should be noted that the reporting rate to NRLS will increase after this date.

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 (%)**
18-19 Q1	1565	4	0.25	4	0.25
18-19 Q2	1384	7	0.50	4	0.28
18-19 Q3	1322	12	0.90	9	0.68
18-19 Q4	1216	3	0.24	15	1.23
Totals:	**5487**	**26**	**0.47**	**32**	**0.58**

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

In 2018/19, the Trust uploaded a total of 5487 patient safety incidents to the NRLS, compared with 5764 reported in 2017/18 Quality Accounts. 95% of the 5487 incidents resulted in no harm or low harm.

The Trust reported a total of 58 severe harm and patient safety related death incidents in 2018/19, compared to 65 incidents in 2017/18 (as at 9.4.19).

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has increased to 0.47% when compared with 0.38% in 2017/18. The percentage number of patient safety related deaths (uploaded to NRLS) has continued to decrease to 0.58% when compared to previous years and last year which was 0.74%.

It is difficult to make comparisons in annual figures, because not all incidents reported up to 31.03.19 will have been reviewed and uploaded to the NRLS at the date of the report.

Nationally, it is believed that organisations that report more incidents usually have a better and more effective safety culture, with which we agree. If we understand what our incidents are, we can learn and improve our services. Each of our business delivery units have a systematic way for reviewing learning from their incidents.

2.3.7Learning from deaths

The Serious Incident Framework 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, further enhances the processes of investigation and learning.

During 2018/19 (at 8/4/19), 2583 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:

- 692 in the first quarter;
- 654 in the second quarter;
- 657 in the third quarter;
- 580 in the fourth quarter.

By 8 April 2018, 274 deaths met the Learning from Healthcare Deaths review criteria. 89 were/are subject to case record reviews and 94 were/are subject to investigations. In addition, 91 deaths were certified.
Table 1

	Case record reviews/Structure Judgment Record Reviews	**Investigations** (including serious incident, service level, safeguarding, LeDeR)	**Death Certified**	**Total**
Quarter 1	21	18	10	49
Quarter 2	26	15	15	56
Quarter 3	20	29	30	79
Quarter 4	22	32	36	90
Total	**89**	**94**	**91**	**274**

In 89 cases, a death was subjected to both a case record review and an investigation. All deaths that had an investigation also have had a first stage case note review completed by the manager prior to any investigation commencing.

The number of deaths in each quarter for which a case record review or an investigation was or is being undertaken is:

- 39 in the first quarter;
- 41 in the second quarter;
- 49 in the third quarter;
- 54 in the fourth quarter.

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 jointly developed a policy and use a common reporting dashboard that brings together important information. The 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. As an Alliance, we will continue to review this decision and will continue to support work to develop our data and general understanding of the issues.

During 2018/19, we conducted 183 investigations or case note reviews.

Our Structured Judgement Reviews for deaths are conducted by trained reviewers from a clinical background (e.g. medicine, nursing, physiotherapists) using an approved template. Each phase of a person's care is considered by the reviewer. Three Structured Judgement Reviews resulted in an overall poor rating. Feedback to clinical teams has been given for action. All completed reviews are discussed at either our Clinical Risk Panel or Mortality Review Group to agree next steps, which may include further investigation.

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.

14 Serious Incident investigations have been completed so far in 2018/19. These resulted in 34 actions for improvement being identified, however, these were not contributory to the death, and no specific root causes were found.

In relation to each quarter, this consisted of:

- 1 representing 0.14% for the first quarter;
- 1 representing 0.15% for the second quarter;
- 1 representing 0.15% for the third quarter;
- 0 representing 0% for the fourth quarter.

The same methods for case record reviews and investigations were used during 2017/18.

From the Structured Judgement Reviews completed to date, there have been 3 cases that resulted in an overall poor rating. A summary of what we have learned from all reviews is provided below:

- Completion of risk documentation where the overall understanding and formulation of the suicide risk wasn't clear and important clinical information seemed to have been overlooked.

- Not making use of readily available information in terms of risk e.g. the extent of substance misuse, intrusive sexualised thoughts and thoughts about self-harm.
- Not pursuing what might have been an option in terms of a psychological intervention.
- The reviewer identified that the use of heroin, which was new, was not explored in any depth and that although awaiting an appointment with a drug and alcohol service, expediting this may have been indicated.
- Record keeping issues: Sainsbury's level 1 completed with only second hand information; Comprehensive assessment started but incomplete. There was the service user's views added however the practitioner had never seen or spoken to the service user; unclear from documentation if patient was being seen by a service or not as there was limited information entered when accepting the referral. Crisis and contingency plan was based on information that had pulled through from a previous assessment 2 years before, which was out of date.
- Care pathway: Delays between accepting of the referral and the offering of an appointment. Patients who did not attend for an assessment but no further appointment was offered, with no contact attempted to ascertain a reason for this.
- Communication issues: No inter-agency communication with regards to people who did not attend for an assessment or were discharged. Lack of communication with other agencies, and lack of involvement in assessment in any way.

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. From the investigations into deaths that have been completed to date, there have been no root causes identified. However, we have identified 34 actions which are likely to result in improvements in practice. These were not contributory to the death. Some of the main themes are:

- Communication issues: liaison with other agencies, including developing information sharing agreements; improving communication with referrers; developing guidance on communicating with other services; communicating with service users regarding future appointments and improving information in discharge letters.
- Policy and procedure: ensuring risk assessments are updated; ensuring crisis and contingency plans are in place for new referrals; ensuring copies of the care plan are given to the service user; ensuring transfers of care are completed in line with the CPA operational policy
- Liaison with families and carers issues: ensuring staff have access to the customer services leaflet; clarity of the roles of individual teams in the trust; providing information to families about the function of a service.
- Record keeping actions focussed around clinical record keeping; completeness of records and quality of information; ensuring crisis and contingency plans are updated following referral to the community team; recording family point of review; ensuring risk assessments and plans are updated in line with Trust policy.
- Risk assessment issues related to: ensuring review of level 1 risk assessment post visit; ensuring risk and care plans are updated in a service user with long term history of mental health problems discontinue medications and at transfer between teams; completion of level 2 risk assessments.

During 2018/19, we have:

- Developed a Clinical Mortality Review group, where we shared information arising from investigations and case record reviews completed in the period 1.4.17-31.10.18. The group undertook thematic analysis to identify common themes and messages for sharing across the Trust.

- A new clinical information recording system, SystmOne was implemented in February 2019 which aims to improve clinical record keeping.
- Continued implementation of suicide prevention work
- This year we have focussed on ensuring feedback from structured judgement reviews has been provided to clinical teams to ensure local action as needed.

During 2019/20 we will continue to learn from deaths occurring in 2018/19:

- Further analysis of thematic information through the Clinical Mortality Review Group
- Introduction of a Trust wide Learning forum
- Plans are in place to implement new methods of recording risk formulation within SystmOne, which is hoped will address this common theme.
- Sharing learning from choking incidents
- Continued implementation of suicide prevention work
- We will continue to embed our learning from deaths processes.

Work continues to assess the impact of actions taken. As our processes embed, this will be developed.

20 case record reviews and 22 investigations were completed after 20.04.18 which related to deaths which took place before the start of this current reporting period. They occurred in 2017/18 and were included in figures for 2017/18.

2 cases representing 0.06% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the same methodology for case record review and investigation as described above. Themes from deaths occurring between 01.04.17 to 31.03.19 are now reviewed collectively.

In our 2017/18 Quality Accounts we reported on the number of deaths resulting in a case record review or an investigation. This has been reviewed and 2 cases representing 0.06% of the patient deaths during 2017/18 were judged to be more likely than not to have been due to problems in the care provided to the patient. Immediate and local actions were taken.

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

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 2018 to 31 March 2019 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/ SystmOne 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 3 instances where the clock start dates were incorrect based on the patient notes and information held in RiO / SystmOne 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 2018/19 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 placements 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 2018 to 31 March 2019
- Recalculate the indicator presented in the Quality Account using the data provided to us as reported on page 34.

Outcome: the auditors identified one case where there was incorrect recording of the start date and two cases (one of which also had the error on the start date) where there was an incorrect recording of the stop date based on the information held within RiO / SystmOne and patient notes. Based on testing that has been performed have issued an unmodified opinion.

Local indicator

For 2018/19 the Members Council Quality Group has agreed that the local indicator will be Cardio Metabolic Assessment.

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 2018 to 31 March 2019
- We agreed our sample to the underlying data held within RiO/SystmOne 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 one case (1/25) where there was no evidence that an assessment had been completed.

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 2018/19 Annual Report highlighted the following:

- The number of exception reports had been low during this period, 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 with more time given to this at all induction sessions 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 with more data available than in the previous year.

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 data
	2018/19 * (April – Feb 19)
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	87.3% (April – March)
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards	Due June 19
b) EIP services	Due June 19
c) community mental health services (people on care programme approach)	Due June 19
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	*53.38%* *Including March primary data*
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	*92.30%* *Including March primary data*
ii. within 18 weeks of referral	*99.34%* *Including March primary data*
Admissions to adult facilities of patients under 16 years old	0
Inappropriate out-of-area placements for adult mental health services	344 (this is the average per month for April – March data)

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Section 3:
Our performance in 2018/19

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 2018/19 we set ourselves a set of challenging goals, which were in line with our quality strategy priorities. 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 and WELL LED (Care Quality Commission) as a framework to organise our quality improvement priorities.

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 36-37.

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 priority improvements: 2018-19. Summary tables

Below is a list of quality priorities that the Trust identified for improvement in 2018/19. Achievement has been rated using a Red/ Amber / Green (RAG) rating scale.
Key: Green – achieved 90% plus of goals in set timescale; Amber – progress is being made, out of timescale; red- not achieving goals set.

SAFE		**Goal**	**Status**
S1	Improving physical health care for people with mental illness	100% CQUIN achievement and updated patient safety strategy	Green
S2	Safer staffing	CHPPD review Workforce strategy update New roles for nurses and AHP's	Green
S3	Patient safety strategy	Updated strategy	Green
S4	Improving our environments	95% participation rate for Infection, Prevention and Control audits 100% environmental audits have an action plan Response rates to jobs logged with estates achieved	Green
S5	Safeguarding developments	Enhance safeguarding record keeping Hold a conference Increase awareness in relation to human trafficking and child sexual exploitation	Green

EFFECTIVE		**Goal**	**Status**
E1	Policy and procedures	Revised governance process	Amber
E2	Nice guidance	Performance reports by BDU	Green
E3	Support for the workforce	Achieve clinical supervision KPI Meet appraisal KPI Promote the role of FTSUG	Green
E4	Electronic records system	Implementation of SystmOne	Green
E5	Effective care pathways	Development of a clinical pathway for people with personality disorder	Green

CARING		Goal	Status
C1	Staff Friends and Family Test (Staff FFT): staff recommend the Trust as a place of care and treatment	80% of staff recommend the Trust as a place for care and treatment	Amber
C2	Patient experience: Friends and Family Test	Achievement Trust wide FFT key performance indicators Increase number of volunteers	Green
C3	Nursing strategy	Update Nursing strategy and achievement of nursing strategy objectives	Green
C4	Allied Health Professional Strategy	Achievement of allied health professional strategy	Green
C5	Volunteer programme developments	Increase volunteering opportunities within the Trust	Green

RESPONSIVE		Goal	Status
R1	Work with partners on ICS programmes	Participation in regional programmes	Green
R2	Unity centre developments	Complete the Unity centre development	Green

WELL LED		Goal	Status
W1	Quality improvement toolkit	Toolkit developed and available on Trust intranet	Green
W2	Learning lessons across the Trust	Framework developed and website page established	Green

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 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

S1. Improving physical health care for people with mental illness

S1a. 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 Accident and Emergency (A and 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.

Since 1 April 2016, the access and waiting time standard for early intervention in psychosis (EIP) services has required that more than 50% of people experiencing first episode psychosis commence treatment with a NICE approved care package within two weeks of referral. This standard is targeted at people aged 14-65 in line with NICE recommendations. By 2020/2021 NHS England want the standard to be extended to reach at least 60% for people experiencing first episode psychosis. Access to high quality healthcare and interventions is one of the key requirements of the NICE quality standard but a previous audit undertaken by the Health Quality Improvement Partnership (HQIP) found this was only happening in 22% of cases. Improving access to high quality physical healthcare in EIP services is seen as essential in improving longer term physical health outcomes for people with psychosis and a specific focus on EIP services within this Commissioning for Quality and Innovation Payment Framework (CQUIN) is therefore necessary.

This year's cardio metabolic national audit of inpatient and community based mental health services were undertaken between September - December 2018, which is known as 'Quarter 3 (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 (NCAP). The results from these audits are not expected until sometime between April – June 2019/20 (Quarter 1, Q1). However, the commissioners agreed to assess our performance based on local results and reconcile as appropriate once the national results are available.

Our internal analysis of our submissions shows:

Area	Threshold	Sample number		Achievement
		Pass	Fail	
Early intervention in psychosis	**90%**	**252**		**98%**
		248	**4**	
Community mental health teams	**75%**	**100**		**82%**
		82	**18**	
Mental health inpatients	**90%**	**50**		**98%**
		49	**1**	

Undertaking physical health screening for people with mental health problems and learning disability will continue to be a priority for the trust. We will be extending our cardio metabolic assessment tool to include access to relevant national screenings, medicines reconciliation and review and general physical health enquiry into sexual health and oral health. We will develop the tool with primary care colleagues so that it will be the same across primary and secondary care to ensure services user's care is well coordinated and promotes good communication.

S1b. revise our physical healthcare strategy for people with mental illness

As described above, people with severe mental illness are at increased risk of poor physical health, leading to an increasing need to focus on the physical health of people with mental health problems and learning disability, when compared with the general population.

In 2018/19 we took the following action:

- We have a revised draft physical health care strategy that has now gone out to consultation with stakeholders. It is envisaged for this to be further consulted with wider partners such as our commissioners.
- A task and finish group has been reviewing the establishment of an integrated pathway to enable a collaborative approach to managing and reviewing physical health of patients touching any aspect of primary or secondary care mental health service.
- The Trust Resuscitation training now encompasses the principles of RAMPPS training (Recognising and Assessing Physical Problems in Psychiatric Settings).

The next steps for 19/20 are:

- To complete engagement and consultation with commissioner links via GP mental health lead and task and finish group

- To take the strategy following consultation and review, through relevant process for Trust-level approval

- To cascade the approved strategy widely and support embedding the principles of providing high quality care for patients and carers

S2. Safer staffing

Our vision is to continue to create a sustainable workforce to meet the demands of inpatient mental health wards and community teams within our Trust.

Given the national shortage of registered nurses, difficulties recruiting and retaining staff, the organisation has taken action to ensure that the staffing establishments have been reviewed to ensure any impact on quality is minimised and mitigated. As a Trust we continue to experience difficulties in recruiting registered nurses to our inpatient wards so our initial focus has been in this area. Furthermore, the organisation needed a centrally co-ordinated system for provision of bank or agency staff.
These initiatives were to ensure that the Trust was doing everything it could to improve safer staffing and the management of resources. The focus was always to improve quality and drive up safety for service users, carers and staff.

Actions we have taken in 2018/19 to meet this vision:

- We have completed a full establishment review utilising several indicators including care hours per patient day, (data that gives ward managers, nurse leaders and hospital managers a picture of how staff are deployed in relation to numbers of people they care for). Based on this review, recommendations to increase the registered nurse establishment in several of our inpatient areas were made to our executive management team. These recommendations have been fully accepted and incorporated into the workforce plans for this coming year. This should lead to more appropriate staffing and continue to reduce nurse agency spend.
- Work has commenced on safer staffing within the community mental health service.
- We have recruited 65 medical staff onto the bank and are looking at how to ensure all roles are on e- rostering.
- The roster system continues to be rolled out across teams within the organisation. We will re-launch the roster policy and are establishing check and challenge events with managers to ensure that they are utilising the system it to its full potential, allocating staff where needed.
- The development of the Trainee Nurse Associate (TNA) has provided opportunities to bridge the role between Health Care Support Workers and graduate nurses, supporting career progression, increasing the supply of nurses and enabled nurses to take on more advanced roles.
- The introduction into our workforce planning of Advanced Clinical Practitioners will ensure a clearer focus on clinical practice, clinical leadership and high quality patient care.
- We have developed and implemented a recruitment and retention group which looks at all available options in these areas. Our international recruitment plan did not result in recruitment from overseas; we were unsuccessful in identifying appropriate individuals.
- Recruitment of bank only staff continues to grow, we now have in excess of 530 staff covering all disciplines within our trust.
- Increased fill rates and fewer vacancies. Improved and sustained quality of new employees, both on bank and agency through the establishment of the values based assessment centre.

In 2019/20 we will continue our work to ensure we have a workforce to support the clinical need of the people who are in our services. Some steps we will take are:

- Triangulate our data to ensure we have accurate, up to date information to inform workforce planning.
- Continue to working closely with wards where there is pressure on meeting staffing numbers.
- Support the development of the national 'acuity' staffing tool for community teams and implement this when it becomes available. Work with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time.
- Establish check and challenge events with managers to ensure that they are utilising e-roster to its full potential.
- Continue aligning Safer Staffing initiatives with new Trust Workforce Strategy
- Continue to review the medical bank capability and explore their migration onto the e-rostering system
- Continue expanding the bank to support other areas including Allied Health Professionals (AHPs) and community teams
- Interpret and act upon Care Hours Per Patient Day (CHPPD) statistics which will be reported monthly from January 2019.

S3. Patient safety strategy

Through the implementation of the Patient Safety Strategy the Trusts aims to reduce frequency and severity of harm resulting from patient safety incidents and also to reduce associated costs, both personal and financial.

For 2018/19 we said we would implement human factors training for a selection of staff across the Trust as part of our overall strategy for reducing harm.

Human factors

Keeping patients safe in our NHS healthcare system is high priority.

Human factors, uses scientific methods to improve system performance and prevent accidental harm. The goals of human factors in healthcare are twofold: (1) support the cognitive and physical work of healthcare professionals and (2) promote high quality, safe care for patients. There is increasing agreement that implementing human factors across the healthcare workforce may have a large impact on reducing harm.

Human factors is an established scientific safety discipline which is used in many safety critical industries e.g. railway and aviation.

A human factors approach can help staff to understand how patient safety issues start and how patient safety issues may be avoided.

We have continued to develop our use of Human Factors methodology:

- A Human Factors section has been developed, on the Patient Safety intranet page.

- E-learning is available for all staff as Bronze on-line training. Silver level training is also available and relevant staff have attended.

- Human Factors continue to be examined as part of investigations

- The Patient Safety Support Team have developed a Significant Event Analysis template as a tool which can be used to analyse an adverse event, which helps teams to focus on Human Factors. This tool is part of the Systems Analysis training.

We have also had success where teams have chosen to implement ***safety huddles*** across the trust. Involvement with safety huddles is entirely voluntary, and to be successful, the identification of harms must be done by the team.

Significant achievements have been made in reducing harm during 2018/19 (note award goals differ for each team based on their historic data):

Summary of achievements in 2018/19:

Team	Focus	Baseline	Days between achieved	Award
Chantry (OPS)	Falls	0.8 falls/week	33 days without a fall	Bronze
Willow (OPS)	Falls	1 fall in 8 days	>100 days without a fall	Platinum
Willow (OPS)	Violence and Aggression	Average 31 days between	70 days without a violence or aggression incident	Silver
Stroke unit	Falls	1 fall/6 days	64 days without a fall	Platinum
Neuro Rehab unit	Falls	18 days	43 days without a fall	Silver
Beechdale (OPS)	Violence and aggression	2.65/week	39 days without a violence or aggression incident	Gold

Additional success to support our aim to reduce frequency and severity of harm resulting from patient safety incidents have been achieved through the Sign up to Safety programme.

Sign up to Safety data for 2018 has shown positive outcomes with our targets being met or exceeded. This has resulted in reduced costs, both personal and financial associated with patient safety incidents.

Harm (type) to be reduced	Target reduction	Actual reduction
New pressure ulcers that are attributable to SWYPFT care and avoidable	50%	74%
Inpatient falls	15%	36.4%
Inpatient falls resulting in moderate/severe harm or death	10%	21%

Moderate harm and above to patients in incidents that resulted in restraint	30%	71.4%
Prone restraint (as a percentage of all restraints)	30%	30.7%
Unintended missed doses of medication	Reduce frequency	8.8% reduction

Our work to improve the duration of prone restraint will continue during 2019, along with a reduction in the use of restrictive physical interventions and improvement in medicine omissions.

S4. Improving our environments

For 2018/19 we said we would improve our clinical environments, ensuring they are fit for purpose, with support from our Estates teams. Maintaining a safe environment is pivotal to effective care delivery. We said we would achieve:

- 95% compliance (participation) rate for all infection, prevention and control (IPC) audits
- Ensure all environmental audits have an action plan
- Ensure all inpatient areas have a ligature assessment completed
- Monitor response rates from the time a priority job is logged and responded to by estates

Infection, prevention and control audits

We focused on this area to provide assurance that our clinical teams are participating in infection, prevention and control audits which help to improve safety for patients, service users, staff and carers.

The table below shows the rates of participation in IPC audits

Name of ward	Participation rate (% of audits that the team participated in).	Name of ward	Participation rate (% of audits that the team participated in).
Ryburn	100%	Chippendale	83% (5/6)
Sandal	100%	Hepworth	100%
Thornhill	100%	Johnson	100%
Appleton	100%	Priestley	100%
Bronte	100%	Waterton	100%
Newhaven	100%	Horizon	100%
Ashdale	100%	Elmdale	100%
Ward 18	100%	Ward 19	100%
Beechdale	83% (5/6)	Lyndhurst	80% (4/5)
Enfield Down	100%	Stanley	100%
Nostell	100%	Chantry	100%
Walton	100%	Stroke unit	83% (5/6)
Neuro Rehab	83% (5/6)	Clark ward	100%
Beamshaw	100%	Melton suite	83% (5/6)
Poplars	100%	Willow	83% (5/6)

In summary:

77 % (23/30) of wards participated in all IPC audits

100% (30/30) of wards participated in more than 80% of audits.

The audit that seven teams did not participate in was the decontamination audit .There is no valid reason for non-participation and we have reviewed our systems to ensure 100% participation by all areas that where the audit is applicable.

All environmental audits have an action plan

Across the Trust a multi personnel visit approach has been adopted to undertake environmental audits. Reports and action plans have been provided to service areas to support improvement. The process was positively championed by wards and clinicians, in partnership with estates specialist advisors. The Health and Safety audit 2019 had a **86% participation rate.**

Ensure all inpatient areas have a ligature assessment completed

The Trust has introduced the Manchester ligature audit tool across all inpatient areas which has provided consistency and allowed benchmarking across the inpatient areas to look at effective ways of effectively managing risks. In 2018/19 this was rolled out into community bases. All services across the Trust have processes in place for logging and monitoring of priority jobs to be completed by Estates.

100% of inpatient areas have completed a ligature risk assessment.

Monitor response rates for time a priority job is logged and responded to by estates

Our Estates Department aims to attend to all reported estates issues in a timely manner and has a system that is set up with a number of response times depending on the priority of the call. All calls that affect patient care are prioritised.

Staff have the ability to log calls 24/7 via an intranet portal and out of normal working hours (from 16:00) the department initiate an emergency on call system giving access to managers and engineers until 08:00 the next working day via an emergency telephone system.

The department have a set of weekly key performance reports which show attendance against target for all call priorities. Current performance is shown on the table below:

Priority rating of calls	Performance target	Achievement
SLA 1 (Emergency)- where attendance must be within 4 hours and resolved within 16 (based on a 8 hours day 08:00 – 16:00)	100%	100%
SLA 2 (Urgent) – Where attendance must be within the day and resolved within 3 days.	90%	96%
SLA 5 (Non Urgent) – Where attendance must be within 5 days and resolved within 10 days.	80%	81%

A Dashboard report is prepared monthly with a quarterly exception report being presented at the Estates trust action group and failure to meet targets are discussed during weekly team meetings.

S5. Safeguarding developments

For 2018/19 we said we would strengthen our safeguarding offer by focusing on key national initiatives. We focused on:

- Human trafficking
- Making Safeguarding Personal
- To enhance quality assurance and safety we introduced a method of ensuring the safeguarding footprint was visible within clinical records
- Hosting a safeguarding conference
- 'Are you afraid to go home tonight?'

Human trafficking

Human trafficking was a key focus area at our safeguarding conference in 2018. The quarterly safeguarding link professional forum invited 'Hope for Justice' to present around the issues of human trafficking in 2018. This has improved understanding of issues and helped to provide awareness of how to raise concerns, which has a positive impact on patient and staff safety. The safeguarding team have attended a number of multiagency meetings around this agenda when appropriate and remain in the loop of communications. They have also advertised and promoted a number of specific training opportunities around this agenda within the organisation, again raising awareness of the issues. Two briefs have been produced and circulated on the trust internal communications.

Making Safeguarding Personal'

The Trust has promoted the 'Making Safeguarding Personal' (MSP) agenda within training, supervision and feedback within the incident management system. Specialist advice from the safeguarding team around vulnerable adults includes the need to ask what outcomes the person wants. Two audits have been undertaken to consider the voice of the adult and whether or not staff are considering making safeguarding personal within their interactions with service users and evidencing this within clinical records Evidence considered within the second audit identified a clear improvement. The safeguarding team are required to provide assurance on behalf of the organisation to our local Safeguarding Adult Boards, this included progress on MSP. MSP supports our service users in making decisions and taking control around actions taken on their behalf. The process is person led and outcome focused.

Safeguarding footprint in clinical records

Following the provision of safeguarding advice by the safeguarding team, this is recorded within the clinical record. The advice system has been further refined to ensure patient confidentiality is maintained. Additional work on Datix allows the specialist safeguarding advisers to send messages through the communications section advising staff of actions required, advice and uploading of documents The Team have also worked with SystmOne to ensure that the safeguarding documents are available. This work impacts on overall patient care and safety, seeks to improve quality and ensures a timely response in terms of advice to our staff.

Safeguarding conference

The safeguarding team hosted 'Hidden in Plain Sight' Safeguarding Conference in March 2018 and 'Thriving beyond Surviving' Safeguarding Conference again in March 2019.

The feedback for the 2018 conference was very positive, the 2019 feedback has yet to be analysed. Initial feedback verbally and through social media is excellent. The conference promotes continuous educational development to a range of staff, volunteers and students who deliver care to the people who use our services, it also promotes the 'Think Family 'agenda and is underpinned by our Trust values.

The development and hosting of a safeguarding conference demonstrated organisational commitment to the safeguarding agenda. It also enabled a range of professionals to come together, network and gain further knowledge and understanding around a range of issues affecting society. This broadens awareness and raises the profile of the agenda.

Are you afraid to go home tonight?

The Safeguarding Team have developed the notion of 'Are you afraid to go home tonight?' through the identification of champions who will receive specific training and identification badges. Posters will be developed and placed on the back of toilet doors alerting service users and staff about where to seek specific support. This was launched at the 2019 safeguarding conference and will be further developed an embedded throughout 2019.

Our work focussing on aspects of safeguarding will continue in 2019, with specific focus on:

- A strategy for child sexual exploitation.
- Ensure the safeguarding footprint is evident across all areas of patient safety including pressure ulcers, immediate life support and reducing restrictive physical interventions.
- Promote sexual safety on in-patient wards.
- Raise awareness and understanding of Hoarding and self-neglect across the organisation.
- Utilise the use of social media to promote safeguarding.
- Further embed the 'Are you safe to go home?' agenda.

What next?

The quality initiatives in the SAFE domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: to continue the work we have started on improving our workforce by implementing safer staffing initiatives, continue to improve our patient safety strategies to reduce harm, and continue with the implementation of our suicide prevention strategy.

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 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

E1. Policy and procedure

We have deferred the reporting of the outcome of this project to 2019/20. Work has started with the aim to improve the governance of our framework to support the development, implementation and monitoring of policies and Trust wide procedures, it has not been completed. A new completion date has been set for October 2019.

E2. Nice guidance

In July/August 2017 the Trust reviewed processes to support assurance against the National Institute for Health and Care Excellence (NICE) guidance. We concluded that whilst these processes measured a compliance level against NICE guidance they did not provide the level of assurance required or identify risk associated with being partially or non-complaint. Subsequently we updated the policy and have implemented a new process, which we estimated would take two years to fully implement. The main changes to our policy are:

Review of guidance applicability to Trust service lines - We have now reviewed all applicable guidance to ensure it is core business to our services.

Benchmark assessments- We are currently in the process of reviewing all outstanding guidelines through project groups consisting of specialists from each business delivery unit / service line. As a group compliance is assessed against the guidelines and the risk discussed associated with not meeting all recommendations. All new guidelines are reviewed and compliance rated within 6 months.

Updated **NICE risk grading framework** - This framework allows us to review not only the risks associated with not meeting all the recommendations within the guidelines but it allows us to review the impact that it has on the trust and patient care. Risks that cannot be mitigated are escalated in the Trust to our Operational Management Group. Risks that cannot be managed by the Trust alone are escalated to commissioners.

Review of the membership and duties of the **NICE Steering and Overview Group** (NSOG) - The aim of the quarterly NSOG meeting is to discuss the risks and impact associated with not being fully compliant with the recommended guidelines and where we have resource implications and/ or gaps in the system we have identified escalation responsibilities for key individuals. The actions from these meetings are regularly reviewed until we are satisfied as a Trust we are meeting the recommendations we are not compliant with or that the risks associated with not meeting the guidelines have a minimal impact to patient care.

Our current position is that we currently have 100 pieces of NICE guidance that are applicable to the Trust. 67 Nice Guidelines have been reviewed with 36 assessed as fully compliant (100%), 28 assessed as partially compliant (85+%) and 3 assessed as not met (<84%). We have active plans in place to ensure all our guidance is reviewed in line with the approach identified above.

In recent months, through benchmarking exercises, we have identified a number of themes that are contributing to us not fully meeting these guidelines.

The key themes are:

- Advanced decisions and advanced statements- variation in application across the Trust.
- Inconsistency of patient information i.e. leaflets across the trust.
- Waiting times in child and adolescent services (active plan in place with commissioners

  support to reduce waiting times).
- Sufficient professionals of appropriate ethnic backgrounds to meet the expressed wishes of Black, Asian and Minority Ethnic (BAME) patients.
- Access to psychological therapies (active plan in place with commissioners' support to reduce waiting times).
- Inconsistency across the Trust that services are not informing carers of their statutory right to a carer's assessment (active plan in place in line with CQC action plan from 2018 inspection)

In addition we have 21 technical appraisals, 14 public health guidelines and 81 published quality standards that will be used by the Trust to provide assurance of the quality of care within our services.

Throughout 2019/20 we will continue this process to ensure compliance and act on areas that require the improvement of quality.

E3. Support for the workforce

For 2018/19 we said we would:

- Achieve our clinical supervision key performance indicator for registered professionals.
- Achieve our appraisal key performance indicator.
- Promote the role of Freedom To Speak Up Guardians (FTSUG)

Clinical supervision

The Trust recognises the important role that the appropriate supervision of clinical staff plays both in contributing to high quality clinical and professional practice leading to improved outcomes for the people using our services and also in maintaining the wellbeing of our workforce. The term 'clinical staff' is used to describe all staff employed by the Trust who have direct clinical contact with service users and those who provide supervision to those staff, whether or not they have a professional health care qualification.

Clinical supervision is defined as 'regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part s/he plays as an individual in the complexities of the events and the quality of practice.' (Bond and Holland 2010:15). Clinical supervisors will have undertaken specific training to carry out this role.

Clinical staff, depending on profession and role, will have differing clinical supervision requirements. The supervision of the clinical workforce policy outlines the minimum level of clinical supervision required. Focus in the sessions is based on the needs/issues identified by the supervisee/s.

We pledged that during 2018/19 we would continue with our focus on supervision, building on our achievements in previous years . 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 84.9% in March 2019. The table below shows how we improved and have maintained our performance in this area.

Timeframe	Threshold	2016/17	2017/18	2018/19
Quarter 1	80%	NA	59.3%	82.6%
Quarter 2	80%	NA	61%	83.7%
Quarter 3	80%	NA	64.7%	85.5%
Quarter 4	80%	39.5%	87.6%	84.9%

We set ourselves a goal of achieving and maintain 80% of registered professionals receiving clinical supervision and we achieved an overall Trust figure of 84.9% in March 2019.

Appraisal

The Trust appraisal process helps staff to reflect on what went well, what could have gone better and how we've lived our values and behaviours over the past year. Our values led appraisal is an opportunity for a supportive two way conversation about: staff achievements, personal development and training needs, staff health and wellbeing, and job related objectives

We listened to staff feedback and have made improvements to the appraisal process, including the format of the form and how we review and reflect on the past year. The appraisal process focuses on having good conversations about job related objectives, development, health and wellbeing and our Trust behaviours.

Our performance against our targets for appraisal is set our below:

BDU	Appraisal rate
Barnsley District	97.44%
Calderdale/Kirklees District	99.19%
Forensic Services	97.44%
Specialist Services	96.76%
Wakefield District	97.61%
Support services	100%
Grand Total	**98.12%**

Promote the role of Freedom To Speak Up Guardians

The Trust has always recognised the importance of creating an organisational culture where staff feels able and safe to raise concerns at work including malpractice, service user and staff safety issues, harassment and bullying and fraud. To support this, the Trust established a network of Freedom to Speak Up Guardians (FSUG).

The role of the FSUGs is typically defined as helping to increase the profile of raising concerns, providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled. The biggest issue from the FSUG network was the need for more dedicated time to allow the proactive element of the role to be developed further. An investment of five hours a week of dedicated time was made available to one of the FSUG network from March 2018.

This dedicated time has clearly had a significant impact and enabled the FSUG role and function to develop over the past 12 months. Whilst the dedicated five hours of FSUG time has been a real benefit the network believe that additional time is required to maximise the role and function. A business case was approved by the EMT for a half time secondment to a FSUG lead post. The network feels that there should be a maximum time for someone to be in such a role and therefore there is agreement it should be for a maximum of two years.

The Trust recently updated a national self-assessment tool on the development of freedom to speak up within the organisation. The updated self-assessment is attached. A key action identified from the self-assessment was the development of a high level vision and strategy for the freedom to speak up. Attached is a vision and strategy which has been developed with FSUGs and discussed with Staff Side. The Vision and Strategy have been deliberately designed to be very simple, clear and complimentary to the Trust's overall Vision, Strategy and Values.

The FSUG report that they have had a total of 14 cases raised with them in 18/19, seven of which concern allegations of bullying and harassment on staff.

As part of our campaign to raise awareness we developed a poster (see below.), held coffee mornings, organised drop in sessions, ran a communications campaign and presented to the Members Council, and other staff groups on the role.

E4. Electronic records system (SystmOne)

The Trust has had a mental health clinical record system, RiO in place for a number of years. The system was going to reach end of life in June 2019 at the latest, and would have required substantial re-investment to ensure it was fit for purpose going forward.

Given the changes and developments in clinical practice over this time period and going forward in particular the move from paper records with some electronic recording, mainly of an administrative nature to a full electronic record by 2020, the Trust saw this as an opportunity to look at alternatives to RIO which would provide our staff with a record system that not only supported electronic recording internally but also allowed us to easily share information with primary care (from June 2019) and vice versa and prepared us for the future enabling us to ready for patient access to electronic records by 2020.

The Trust went out to tender in 2017. TPP were the successful bidder and the Trust commenced deployment of the new system (SystmOne) in 2017/18, continuing into 2018/19.

The clinical record system programme adopted an integrated approach to change that brought together practices and principles from programme management and change management with an emphasis on co-production drawing on clinical, operational, technical and system knowledge and expertise. The plan was broken down into three distinct yet interdependent phases. The Co-design phase involved capturing the 'as is' and 'to be' processes that will contribute to the localisation of an established system. The Co-create phase moved the programme in to full scale development of key activities.

Using this approach, the programme team, successfully deployed SystmOne mental health into the Trust in March 2019. We used a two phase approach with inpatients services going live on the 25th February and community mental health services on the 5th March. These services now join general community on SystmOne, which means that the Trust as a single electronic record system across all services.

The Trust is now seven weeks into community go live and eight weeks for inpatient services, early teething issues are getting rectified and already the programme team have worked with professional groups such as medics and pharmacists to amend forms and functionality for ease and practicality of use.

This early work is showing staff how much "easier" it is for the Trust to grow and develop SystmOne into a fully functioning patient record.

The Trust has made the decision to continue to see SystmOne as one of its priority programmes in 2019/20 to ensure we continue to develop and "use" the system as effectively as possible, moving from deployment through stabilisation onto optimisation

Using the proven three phase approach described above, a reduced programme structure will stay in place to support clinical staff from across mental health and general community to develop and future proof the system. Some of the work already in train is:

- New Care Plan template deployed June 2019
- Sharing out with Primary Care – June 2019
- Use of Tasks – September 2019

During June and July 2019, workshops will be held across the Trust using clinical reference groups to develop plans for future improvements including readiness for patient access to records.

E5. Effective care pathways

Following transformation it become apparent that good practice in the care and treatment of people with diagnosed with Personality Disorder (PD) is patchy and inconsistent across the Trust. There are variations in thresholds and inclusion practices at the primary/secondary care interface and significant differences in the Trust's offer to people with the most complex and challenging presentations.

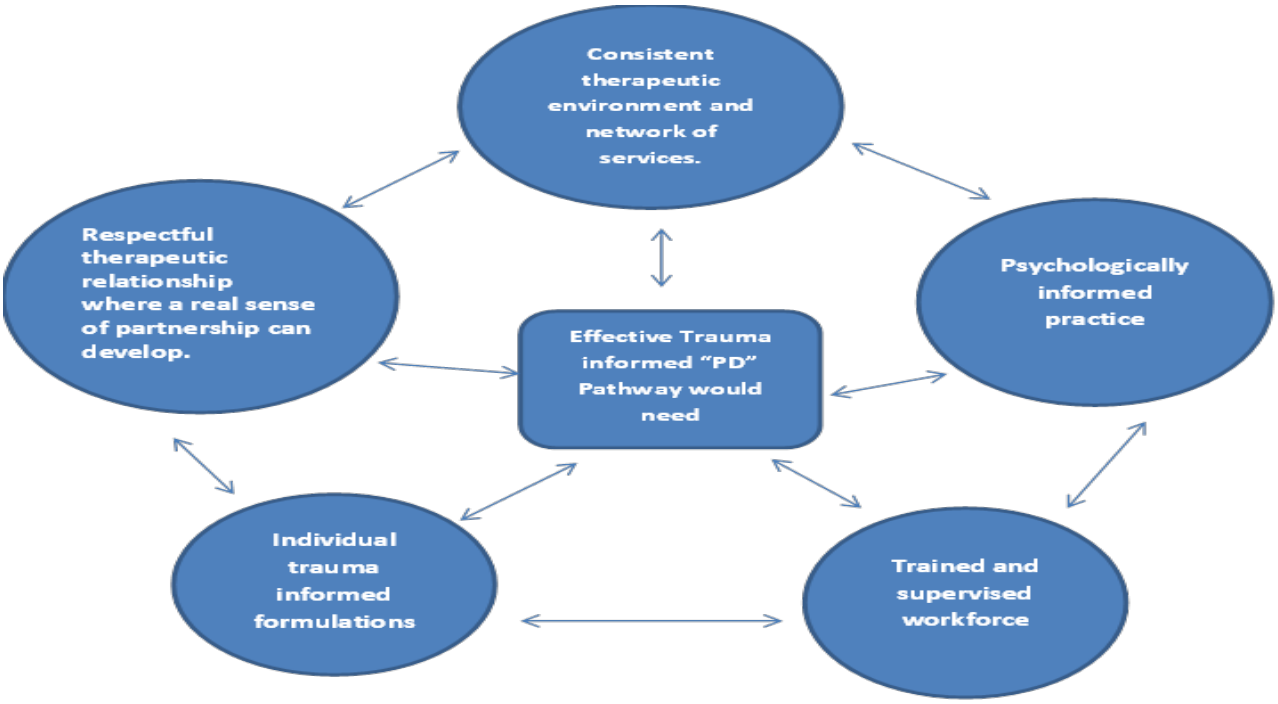
Additionally, whilst the principle of early intervention is well established for people with psychosis, there is concern that late intervention is the norm for PD. Barriers to care and inadequate treatment are recognised as problems which result in poor outcomes, adverse incidents and unhappiness. There is a substantial risk of self-harm and suicide and an over-reliance on Accident and Emergency departments and acute services. Hospital admission is frequently used to manage risk.
At a time when we are admitting more people to beds than we have available in the Trust, and placing high numbers of people out of area, there is a strong clinical and financial imperative for intervening earlier and improving the quality of community care for people diagnosed with PD.

In 2018 a Trustwide project was established to develop a new strategy for the care and management of people who are diagnosed with a personality disorder under the care of adult community and acute services.

The aim was to improve our understanding of the many issues surrounding 'personality disorder' and the services we currently provide; to develop a plan to ensure that our services represent recognised best-practice and to meet the needs of this group consistently, with the aim of improving outcomes and reducing reliance on acute services. A Trustwide expert reference group has supported the development of an evidence-based, trauma informed, best-practice pathway for people diagnosed with personality disorder. In the course of the project we have learned that it is more helpful to refer to our pathway as a 'trauma informed' approach; reflecting the life experiences of people who acquire the diagnosis of 'personality disorder'.

Whist the original project scope led to a focus on the care and treatment of our most complex service users, usually in the Enhanced pathway, it quickly became apparent that the pathway needed to encompass the entire acute and community system. Therefore, the proposed implementation strategy also

aims to support improvements for the greater number of people diagnosed with PD in the Core pathway and to improve access at the primary/secondary care interface.
The expectation is that the new pathway will be delivered by the existing workforce – as configured post transformation – but that new managed clinical networks will ensure care is consistently delivered in accordance with the agreed pathway. The illustration below summarises the pathway:



	Effective Intervention The SWYPFT pathway for PD (3-Step Plan):	Stage 1	Crisis Management and validation
Step 1	**Assessment, Screening and Formulation.** *Build stability, comprehensive assessment and agree goals and treatment plans*	Stage 2	Containment and Validation
Step 2	**Discovery** *Co-produced, formulation-informed treatment. Working towards change.*	Stage 3	Development of self-regulation
Step 3	**End** *From discovery to recovery. Relapse prevention planning and planned discharge*	Stage 4	Exploration of self and change (where appropriate and needed
		Stage 5	Integration and Synthesis. Development of adaptive strategies for life.

To mobilise this plan, two managed clinical networks are proposed; one in Wakefield/Barnsley and one in Kirklees and Calderdale. The networks will focus on three key areas:

- Consistent and effective management of complex cases in the Enhanced pathway, including seamless care across the acute pathway
- Supporting practitioners in the Core pathway, including Singe Point of Assessment and the interface with primary care and Improved Access to Psychological Therapies (IAPT).
- Introducing an early intervention pathway for emerging PD in high risk populations

The plan is to appoint two PD advanced practitioner to lead managed clinical networks in each of the Trust's business units. Networks will be comprised of identified PD champions/link-workers in every team. The project has identified people for these roles who will be supported, trained and developed to fulfil the role.

What next?

The quality initiatives in the EFFECTIVE domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: policy and procedure system review, introduction of outcome measures, 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 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

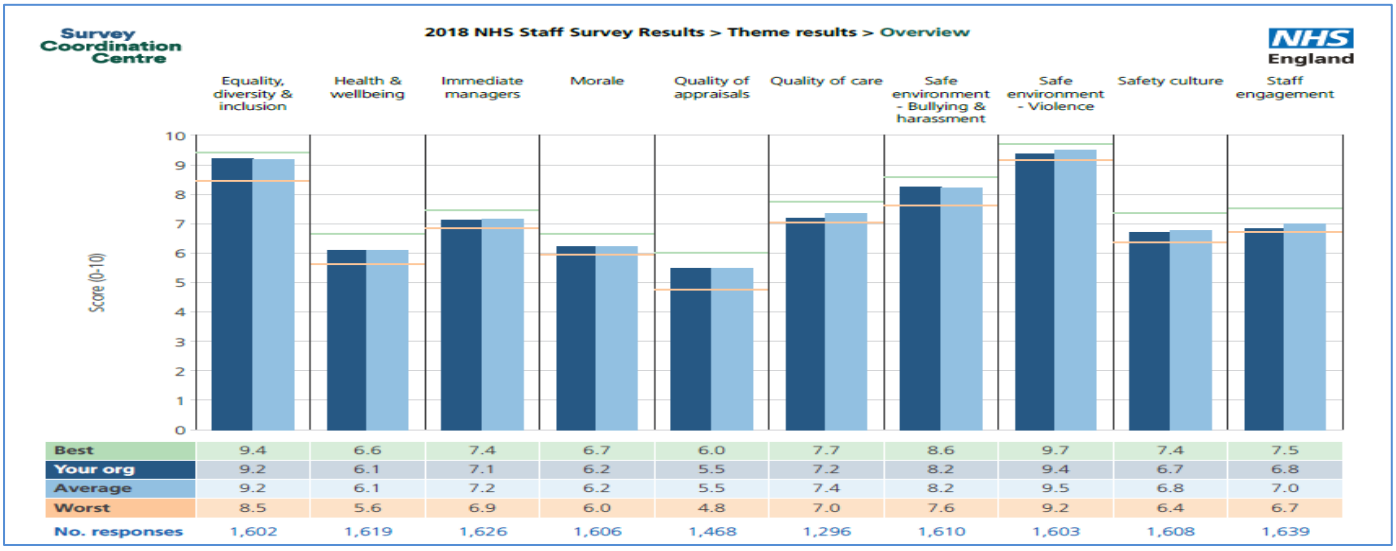
C1. Staff Friends and Family Test (Staff FFT) - staff recommend the Trust as a place of care and treatment

The Trust's Workforce Strategy has a key strategic aim of improving staff well-being, resilience and engagement. Research evidence has shown the links between staff well-being/satisfaction and the quality of care provided to service users/carers.

The Trust conducted the 2018 Well-being at Work Survey with 1700 responses. This showed improvements on the previous year. All key scales were typical of the general working population. Targeted work has been undertaken with services with lower levels of workplace well-being.

The 2018 NHS Staff Survey results shows that levels of workplace well-being and morale are average compared to other similar NHS providers. Given the scale of the recruitment and retention challenge the Trust is focussed on improving these results.

SWYPFT NHS staff survey overview



In July – September (Quarter 2) 18/19 the Staff Family and Friends Test results showed 71% of staff would recommend the Trust as a place to receive care and treatment and 58% as a place to work. We receive positive feedback on our well-being support offer for staff including occupational health, staff counselling and staff retreats. The survey results are used to target support to service areas.

For 19/20 the Trust is focussing on four key workforce priorities these are improving staff engagement, employee well-being, and prevention of bullying /harassment and improving the quality of appraisals. Business delivery units' action plans are being developed in April 19 (Quarter 1). The Trust leadership and management activities are also being targeted at these areas in line with the Trust values and behaviours.

C2. Patient experience: Friends and Family Test

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Experience is one of the three key components of quality and needs to be given equal emphasis along with safety and effectiveness. Evidence illustrates the link between experience and health outcomes i.e. service users who have a better experience of care generally have better health outcomes. There is also a link between experience and cost of care i.e. poor experiences generally lead to higher costs as service users may have poorer outcomes, require longer stays or be admitted for further treatment. In order to improve the quality and experience of all that we do effective measurement is required.

In 2018/19 we have focussed on:

- Volunteers have been utilised across the Trust to collect and enhance service user experience. The Quality Improvement and Assurance Team continue to work with Volunteering Services to enrol new volunteers and support existing volunteers.
- A group has now been established to meet on a regular basis and discuss learning from service user experience surveys, incidents, complaints and compliments. A learning library has been launched that is accessible to all staff via the Intranet. The new service users experience electronic reporting system 'Meridian Optimum' has been launched and is being accessed by staff across the Trust, to review data and view free text comments. Alerts have been implemented to flag any potentially harmful free text comments such as threats of self-harm or harm to others. Services are now receiving pushed reports

via email on a monthly basis. Text message responses are reviewed on a daily basis and action taken in real time if required.

- Bespoke surveys have been co-designed with operational staff and service users, and launched across all inpatient services. Results are accessible via the new service user experience reporting software.
- The Practice Learning Facilitator's (PLF's) routinely review all formal feedback submitted by students on the healthcare placement platform; they then share it with practice areas and the lead for non-medical education and training and any feedback requiring action is addressed.

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.

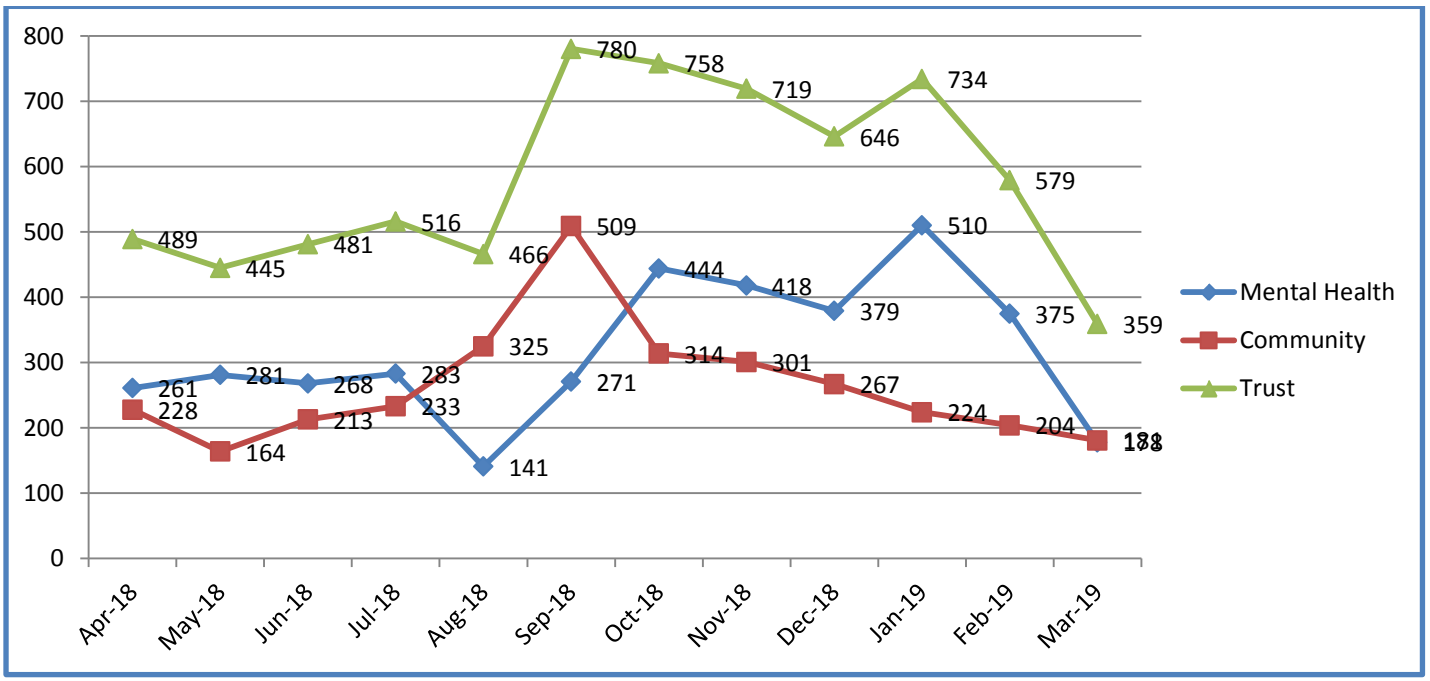
The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results 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, most recently the procurement for the Meridian Patient Experience System and the Envoy text messaging system is being used to collect FFT data for community services.

In 2018/19, the Trust received 6963 individual pieces of feedback, an average of 580 responses per month.

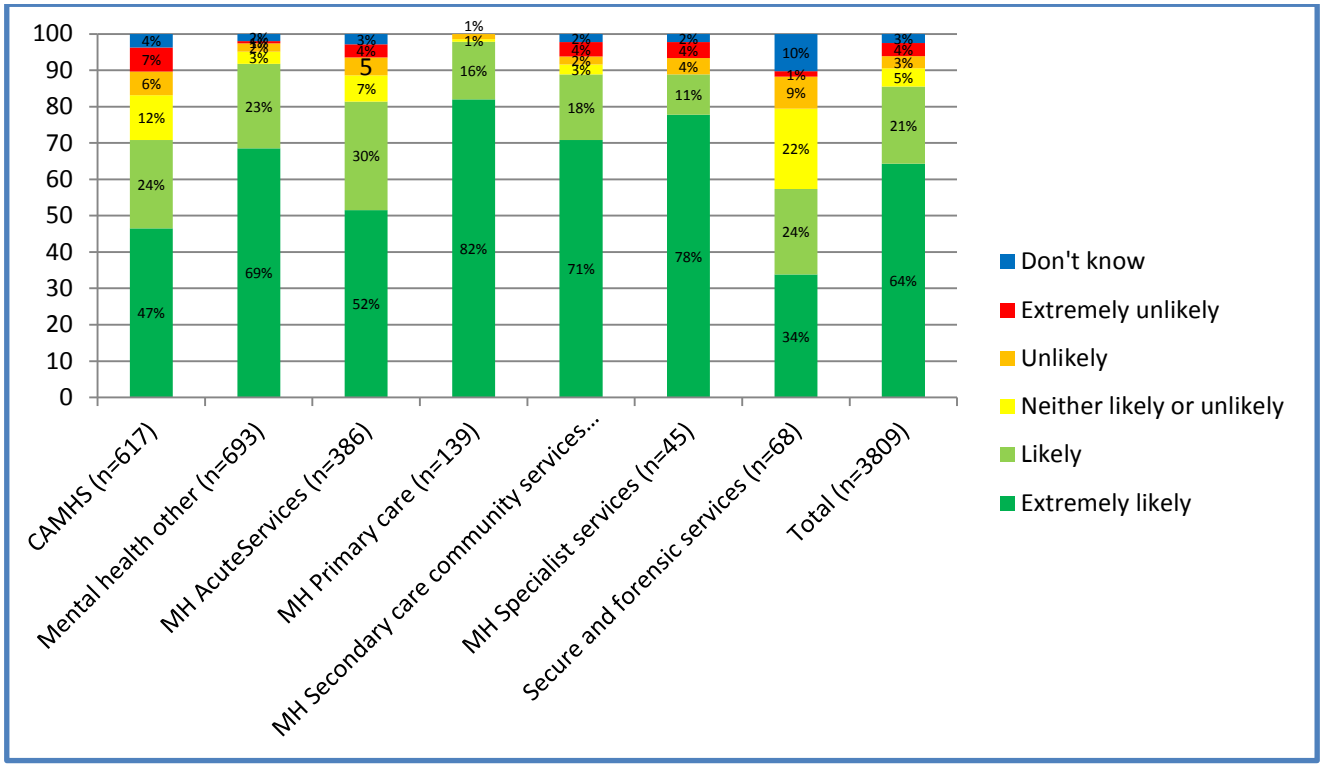
Friends and Family Test	Target	Reporting Period	Q1			Q2			Q3			Q4		
			A	M	J	J	A	S	O	N	D	J	F	M
Mental heath	**85%**	**Monthly**	86%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	94%
Community health services	**98%**	**Monthly**	97%	100%	98%	99%	97%	98%	100%	97%	98%	97%	98%	99%
Trustwide	**90%**	**Quarterly**	**87%**			**97%**			**92%**			**90%**		
CAMHS FFT	**75%**	**Quarterly**	**50%**			**88%**			**86%**			**84%**		
Forensic FFT	**60%**	**Annual**										**58%**		
Learning disability services FFT	**85%**	**Quarterly**	**94%**			**88%**			**92%**			**88%**		

Friends and Family Test **responses** in 2018/19



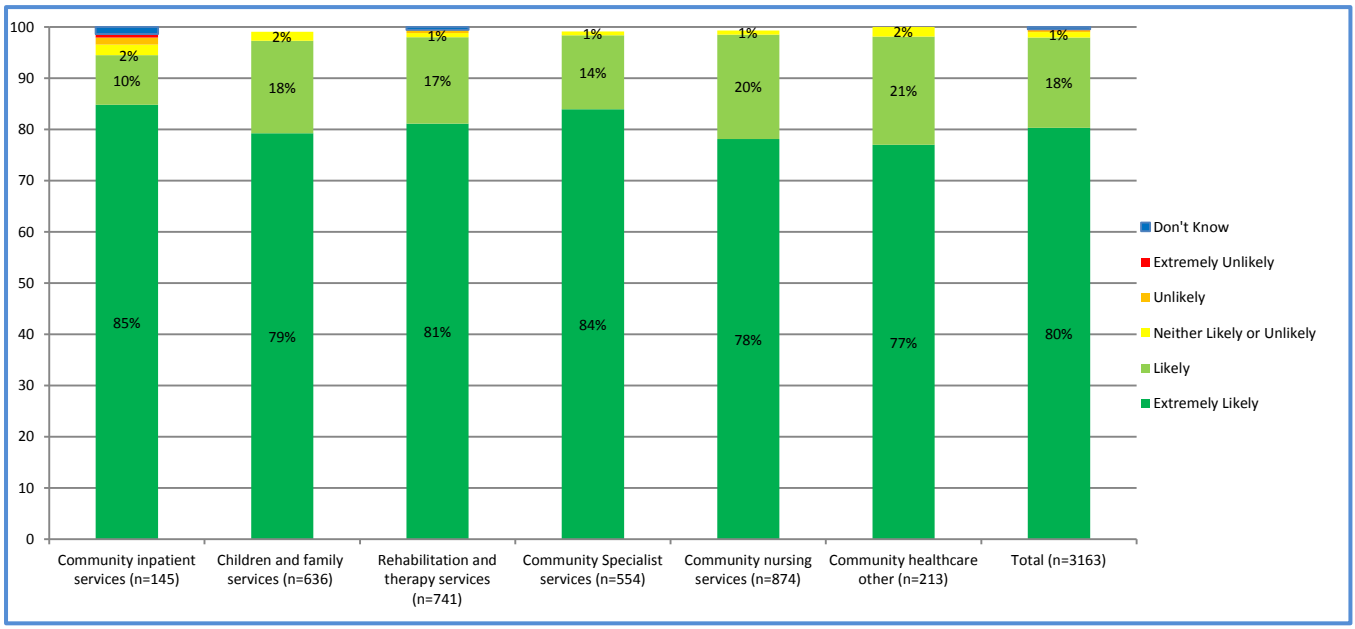
Mental health Friends and Family Test

Note: the response rates reduced from January 2019 due to the availability of the text messaging service, which is a method used by people to provide feedback. This service was disconnected from our system as part of developments with the new clinical record system. The text messgaing facility will be reinstated in 2019.



85% would recommend mental health services, 7% would not

Community services Friends and Family Test



98% would recommend community services, 0% would not.

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. Data is reviewed in real-time and areas of concern, those with 'unlikely' or 'extremely unlikely', are reviewed and, where appropriate, are shared with teams.

Various methodologies are used across the Trust to collect FFT data. The FFT question is asked as part of the inpatient ward patient experience survey on electronic tablets, the text messaging service is used to collect FFT data from community services. We are also trialling the use of a separate login for laptops which can be used by community services whilst on visits. Cards and paper surveys are still used across the Trust.

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. NHS England is currently in the process of reviewing the FFT question and new guidance is expected in April 2019, following this the Trust will expect to have transitioned to the new question in six months. We are expecting to re-launch the FFT across the Trust in July.

Percentage of people extremely likely / likely to recommend services

	Community health	Mental health	Overall Trust Score
2016/17	98%	73%	87%
2017/18	98%	85%	92%
2018/19	91%	85%	91%

	CAMHS	Forensic BDU
2016/17	59%	47%
2017/18	63%	51%
2018/19	71%	57%

Since collection began, community health services have maintained a consistent recommendation percentage of over 90%. 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 2018/19 and work continues with both CAMHS and Forensics on how to best capture FFT from these services.

Developments for 2019/20 include:

- To expand the text message collection service in line with the implementation of SystmOne.
- Design and implement a Trust wide carers survey.
- Implement the updated NHS Friends and Family Test guidance across the organisation.
- Continue to work with operational teams to ensure they are collecting, reviewing and acting upon service user and carer feedback.
- Continue to encourage students to complete formal feedback, monitor the feedback and take action to improve where required. Encourage mentors/educators to invite service users to give students feedback on their performance.

C3. 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 will be monitored through the nursing quality group (NQG). The NQG has met regularly and has representation from the nursing directorate, nurse consultants, practice governance coaches and all business delivery units.

We have made significant progress, which is outlined below.

Key priority	Action taken in SWYPFT
Nurses will experience strong clinical and professional leadership supported by management	All five actions were achieved. There has been strong partnership working between the Nursing Directorate and the Human Resources Directorate to ensure that the workforce is supported. Senior nurse support, workforce plans and quality impact assessments monitoring of professional standards has provided support and enhanced patient safety and quality of care. The Professional Appearance Policy was produced and ratified and is currently being monitored through the internal quality monitoring visits.

Nurses will take every opportunity to add value and demonstrate the contribution of nursing to the care pathway	All five actions were achieved. The nursing workforce has been further enhanced with the development and recruitment of the Trainee Nursing Associate role, the Advanced Nurse/Clinical Practitioner and the recruitment of several lecturer practitioner posts. These roles further enhance the workforce, raise the profile of nursing, enhance professional development and improve patient safety and patient experience.
Nursing practice will be effective, efficient and improve the patient experience	Nurses and allied health professional have access to an advanced clinical practice master's degree programme funded by Health Education England (HEE). Work with local Health Education Institute's (HEI) to pilot new coaching model of mentorship and working with SHU to be an early implementer of new Nursing & Midwifery Council (NMC) standards. SWYPFT are also partners in the District Nursing National apprenticeship programme.
Develop objective and meaningful nursing metrics that measure patient outcomes	Measuring the effectiveness and quality of nursing care will be included in the 2019/2022 Nursing strategy.

In 2019/20 the Nursing Strategy has been updated and the key lines of enquiry are:

- Focus on the needs of patients, service users and carers.
- Workforce, career pathways and new roles
- Staff competence: clinical and professional standards and clinical skills
- Health, safety and wellbeing of staff
- Leadership

One objective which has not been achieved, i.e. to develop objective and meaningful nursing metrics that measure patient outcomes – measuring the effectiveness and quality of nursing care will be included in the 2019/2022 Nursing strategy.

C5. Allied Health Professional (AHP) Strategy

In response to a national initiative 'Allied Health Professionals (AHP's) in to action' we developed an AHP strategy which identified key priorities for the AHP workforce, which aligned to local Integrated care system (ICS) priorities, local clinical commissioning group (CCG) initiatives such as improving physical health care in Mental Health (MH) services, and other national agendas such as Five Year forward.

The table below demonstrates what progress has been made in 2018/19.

Key priority	Action taken in SWYPFT
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)	Self-referral to most AHP services in Barnsley including falls and mobility clinics, with exception of musculoskeletal (MSK) physiotherapy (physio) service where self–referral option was removed at CCG request. Self-referral to learning disability (LD) and MH services available through single point of access (SPA).
Expanding the AHP role to undertake diagnostic tests (e.g. ultrasounds, X-rays)	Physiotherapists in the MSK service request diagnostic tests including bloods, ultrasound, X-Ray and MRI
Extending AHP training for staff (e.g. re-ablement, health promotion, falls and nutrition screening in care homes), service users (e.g. DAPNE) and parents (e.g. early years).	The Trust falls and bone health leads are physiotherapists (one for Barnsley, one for the West), prior to this a consultant physician was the lead. Within LD services speech and language therapy (SLT) is supporting the training of other AHP's to develop an extended role in dysphagia, which helps services be more responsive and reduce risk. Children's SLT in Barnsley provides training for parents and education staff
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.	A number of advanced practitioner roles within AHP professions have been re-established during last 12 months (3 Occupational Therapy (OT) posts). Recognition of the value of this to ensure clinical quality and providing career progression. Has also been sited within the recruitment and retention strategy. We have 1 AHP (physiotherapist) who is a Non Medical Prescriber (NMP) in the west and we have 2 NMP in the MSK service in Barnsley (Physiotherapists) and 3 clinicians qualified to administer local corticosteroid injections for therapeutic use, with a further 2 clinicians undergoing training.
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)	There have been some challenges with recruiting AHP's in to profession specific jobs e.g. Occupational therapy and SLT, (sited in recruitment and retention strategy) therefore, the potential to utilise AHP's to support the undersupply in other roles has been restricted. However, generic positions e.g. Mental Health Practitioner roles are routinely advertised which AHP's can apply for. Work has been done to recruit more AHP staff to the bank.
Continuing to be a high quality provider of student placements to enhance future workforce supply.	AHP's across the Trust have continued to provide a high number of AHP student placements (242 placements during 2018-2019). In Barnsley there have been several events to engage school age children and promote the role of AHP's. In physiotherapy we offer a week long shadowing experience for college students considering physiotherapy as a career.

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.	Occupational therapists working in memory services (Kirklees and Barnsley) are developing knowledge and use of assistive technology to enable service users to remain in their homes e.g. GPS trackers, gas detectors, door sensors, bed sensors, memo minder, calendar clocks. Care phones.
Ensuring clinicians consider both physical and mental health needs, not just single element of care and fostering a self-management approach to prevent relapse.	Occupational Therapist's working in SWYPFT are actively encouraged to utilise skills to address physical health (PH) and mental health (MH) needs e.g. provision of equipment when working in a MH setting. Equipment competency training is delivered on a rolling programme to support retention of skills. Physiotherapy is actively involved in the physical health work in MH and LD services, the lead physiotherapist works closely with the medical director on the development of the strategy and future policy. The dietitians have provided training on IDDSI (International Dysphagia Diet Standardisation Initiative) for nursing, professional and housekeeping staff. This ensures physical issues such as dysphagia can be managed safely. The LD SLT across Wakefield and Barnsley have also provided training for Service providers on IDDSI.
Ensuring all AHPs record timely and accurate information on the clinical records system to meet the data requirements of the organisation and professional standards.	The AHP Professional leads have continued to work with staff to ensure they remain aware of clinical and professional standards for documentation via network meetings and clinical supervision. Compliance is actively monitored by operational managers through use of documentation audits. The AHP professional leads have involvement in review of standard operating procedures e.g. clinical record keeping, care planning and provide training on use of therapy outcomes measures e.g. Therapy outcome measure (TOM), Model of human occupation (MOHO) and its associated tools. Most AHP teams in Barnsley are now on Systmone, this automatically records time records are completed and highlights lack of compliance.
Improve health of the workforce	AHPs employed in occupational health services; OT/PT. Physiotherapy trains staff to use the trusts gym/exercise facilities to promote their health. Dietetics provide information on health eating for staff via pop up displays in canteens. Dieticians work with catering for Nutrition and Hydration week and do healthy eating displays in Dieticians' Week.
Development of vocational opportunities	IPS model (Calderdale). Occupational therapy led. Employment retention and enabling access to employment.

In 2019/20 we will be updating our AHP strategy to align with the objectives for other professional groups, with a shared vision and objectives which put service user, patient and carer experience at the heart of what we do.

C6. Volunteer programme developments

The health and social care system is under pressure to improve the quality and efficiency of services. To meet the challenges and support our program 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.

We have made considerable progress in 2018/19: Currently over 260 volunteers and 25 awaiting placements, equating to 397 hours per week, 508 hours fortnightly 10 hours per month, 48 hours quarterly providing the Trust with 34,164 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.

The service gained 41 new roles across the Trust; these roles have provided a diverse service offer to service users, staff and public. 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.
- Service users and internal staff volunteer to support the Museum.
- Befriender volunteers provide social interaction in our services and communities.

- Faith Chaplains volunteer for our Spirit in Mind providing support and understanding to our services and communities.
- Activity volunteers within the forensic services providing self-care and Art activities.
- Pat Dogs volunteers within our older people and mental health services, provides comfort and wellbeing.
- Research Development – volunteer research champions
- Light touch volunteer roles provides opportunity to be flexible to enhance the volunteer offer
- 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.
- Student from universities and colleges volunteer within our psychology teams.
- Activity volunteers within out Stroke units providing support and companionship
- Speech therapy buddies for our Aphasia cafe
- Library service has volunteers who provide a health information desk and catalogue books.
- There is a volunteer on charitable funds group and all our governors are volunteers.

The service implemented a robust recruitment structure to ensure all volunteers are trained and disclosure and barring service checked to comply with legal and moral obligations to ensure volunteers, service users, stakeholders and services are safeguarded. This process was re-evaluated in 2018 and will continually be evaluated to enhance the offer to volunteers.
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 potential volunteers was lowered from 16 to 14 years of age to accommodate our CAMHS services and communities we serve.

In 2019/20 we plan to:

- Review our plans for further expansion of the service. The next stage requires information from EMT and the services on what they want from our service, which will include how we work with partners to extend volunteering opportunities.
- Renew our Investors in Volunteering accreditation.
- We will be introducing a volunteer forum in December 2019, which will provide a network opportunity for volunteers to have a say and contribute to the work of the Trust.
- Provide additional training for the volunteer supervisors/ coordinators.
- Undertake more development work in our communities, especially our minority communities which are diverse with different faiths and origins.
- Promote the work of the volunteers through the Excellence awards.

All of the above will assist us to ensure that all of the work volunteers do is relevant and of a high quality to build a reputation of excellence, embedding volunteers in its foundations and culture.

What next?

The quality initiatives, in the CARING domain, we will undertake in 2019/20 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 Allied Professional 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 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

R1. Work with partners on Integrated Care System programmes

SWYPFT is part of the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). The members of this partnership jointly agreed a set of areas that we would work on during 2018/19. These areas were identified as it was felt that we would be able to make an impact and improve the offer to service users and carers across West Yorkshire.

Many aspects of this work are still ongoing. Programmes we are involved in are:

Shared acute bed base approach

- Work has focused on sharing good practice across the 3 Mental health trusts.
- This has resulted in SWYPFT adopting a tool that was being used in Bradford for 'criteria led discharge'.

Work with partners to implement new models of care for adult eating disorders and CAMHS

- The new service went live on the 1st April 2018. The West Yorkshire Eating Disorders Community Service is one of eleven national early-wave pilot sites to test new approaches.
- A proposal to build upon the foundation of the established community services in Leeds (and including the service in Huddersfield) was accepted and funded by NHS England with the aim to replicate the community treatment and outreach approach that was working well in Leeds in each of the delivery areas making up the West Yorkshire and Harrogate Integrated Care Service. [Note: there was previously no community ED provision in Calderdale and Wakefield]
- The project had central co-ordination, project management and leadership from Leeds and York Partnership NHS Foundation Trust with SWYPFT supporting.
- The financial case is based on minimising the requirement for out of area placements and avoiding extended lengths of stay with the aim of reducing the cost of out of area placements by £951k.
- The existing community eating disorders services (Leeds and Kirklees) have been supplemented by an additional investment of £810k to form the new community service.

£13m new CAMHS inpatient unit to be built in Leeds

This project is a pilot for two years which focuses on delivering of services for children's admissions differently to prevent them from being miles away from home, trying to keep them local and out of hospital whenever possible. This is through use of locally placed beds and home based treatment teams in local areas.

Adult autism and ADHD (SWYPFT lead)

The focus currently of this work has been to reduce waiting times for Autism spectrum Condition (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) assessment and diagnosis by focusing on sharing evidence based improvements and learning and where possible embedding consistency of approach/standardisation of practice.

Suicide prevention (SWYPFT lead)

There is an agreed development plan for the reduction of suicides across WYHHCP. This plan is being delivered and includes:

- Training for people
- Involvement of experts by experience
- Sharing and using data
- Evidence based pathways and use of technology

A new set of priorities for 2019/20 for WYHHCP have been developed and plans are in place to deliver against these.

R2. Unity centre developments

The function of an adult acute in-patient unit is to provide safe care in the least restrictive environment. The needs of people admitted to these wards vary and may depend on a number of factors such as diagnosis, gender, age and ethnicity. On our acute inpatient wards we provide a service for people with a wide range of needs. It is therefore important to provide an environment that is purposeful, therapeutic and safe. To achieve this we have made sure the service design incorporates a range of internal and external communal spaces, rooms for therapy, arts, music and education for service users in addition to bedrooms, bathrooms, areas for visitors, external spaces and facilities for staff.

In 2018/19 we made the following progress:

- Nostell ward successfully opened in Sept 2018.
- Safe transition achieved due to effective planning between Estates and Clinical Services.
- Lessons learnt from previous Walton and Stanley Ward moves were taken into consideration.
- Service user participation throughout and post move evaluation.

In 2019/20 we plan to take the following action:

- Chantry ward to move into Crofton and ECT to move into re-furbished ECT department.
- Ongoing service user evaluation
- Further development of the Unity Centre/Wards to improve the environment for example displaying of artwork etc.

What next?

The quality initiatives in the RESPONSIVE domain which we will undertake in 2019/20 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 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

W1. Quality improvement toolkit

In 2018/19 we focused on this area as we knew that by developing a systematic approach to improvement that builds capability and capacity to support positive change and innovation across the organisation and within and across communities with our partners remains a priority within the SWYPFT Quality Strategy which was refreshed in April 2018.

In addition, as part of the Trust's Quality Priorities for 2018/19 the following actions were identified as Quality Improvement Projects

- Develop a quality improvement toolkit and website
- Increase 'do and share' improvements.

In 2018/19 we have made the following progress

- Developed a Quality Improvement Toolkit and Website

During 2018/19 and as part of the #allofusimprove initiative across the Trust a toolkit was developed for staff to support them to make improvements within their services themselves but with the necessary support to help them plan. The following were included as part of the improvement toolkit:

- PDSA (Plan, Do, Study, Act) Mini Project Plan
- Cause and Effect Diagram
- PDSA Guidance
- Seven steps to measurement
- Institute for Healthcare Improvement – Quality Improvement Essentials Guidance

These tools can be found on the Trust's website: https://www.southwestyorkshire.nhs.uk/news-and-events/allofusimprove/

Examples of use of the toolkit are:

- PDSA tools were used to support the development of Safety Huddles which bring together members of an MDT at a regular time to highlight and discuss safety and risk issues for patients.
- Cause and effect (Fishbone diagram) was used to support the Out of Area project to analyse and identify root causes.

Do and share improvements

During 2018/19 there were 267 ideas posted on i-hub with 1378 comments and 3581 votes. There were 21359 views of posts that colleagues have made, 1554 page views and 420 colleagues joined the i-hub community during this period increasing the total number of users to 2052 – approximately 50% of Trust employees. The numbers joining and now involved in the i-hub community represents a year on year increase demonstrating significant do and share activity across the Trust.

Of the ideas posted there were a mix of new ideas and insights across the range of challenges set during 18/19 and shares of good practice and events held. Through i-hub and the helpdesk colleagues are brought together across the Trust who can support each other with their expertise, interests or experiences and share.

During 18/19 the key activities were:

- The EyUp! Charity;
- FAB Change Week;
- SystmOne Implementation and
- You Said We Did.

Positive outcomes during this year are:

- Opportunity to share ideas and insights from staff about shaping SystmOne;
- Sharing of Recovery College myth busting facts to encourage staff to help drive the future direction of recovery colleges;
- Promoting the importance of good nutrition and hydration and sharing ideas of how service users can be supported to achieve this;
- Sharing ideas and learning on nutrition support and eating and how to support the clinical needs of service users on wards;
- Sharing knowledge and insight to further develop skills amongst staff to support people with anxiety and depression.
- Sharing of self-help materials to staff to support people in their routine work to help them understand and manage common mental health problems.

What are the next steps for 19/20

Under Improving Care – Safety first, Quality counts; using #allofusimprove to drive quality remains a priority for the Trust during 2019/20.

An annual plan for #allofusimprove has been developed for 19/20 and will focus on:

- A review of the Quality Improvement Toolkit, ensuring that it is simple and straightforward for staff to understand and utilise. Staff will continue to be supported to use the toolkit through the #allofusimprove helpdesk and where necessary through improvement workshops using the PDSA methodology. As part of the #allofusimprove communications, the toolkit and outcomes from using it will be regularly shared and publicised throughout the Trust.
- A refresh of i-hub, ensuring that it becomes a one stop shop to bring staff together to 'do and share' their ideas and insights quickly and with minimum effort. A yearly challenge planner will be created linked to the strategic direction and priorities of the Trust and challenges will be time specific, targeted at everyone across the Trust or specific groups based on their expertise, interests or experience. Working in partnership with the Quality and Improvement Team regular sharing from challenges, PDSA workshops, case studies, learning library and he significant event tool will be publicised.

W4. Learning lessons across the Trust

During 2018/19 a small group of staff from a range of teams have been exploring ideas for how we can improve how we share learning from our experiences, whatever its source, e.g. incident, serious incident, complaint, compliment, audit, patient experience, case note review.

Although there are many examples of sharing learning across the Trust; within teams, between teams and across Business Delivery Units; we wanted to develop a simple systematic method that anyone could use. This development is not designed to replace structures that are already in place, but to enhance them by providing a common format. As a group, we researched what other Trusts were doing, and asked for suggestions from staff on i-hub platform and through trust communication channels. We also looked at the success of our internal Bluelight alerts for sharing learning urgently across the Trust. We used the information to help develop our ideas.

In 2018/19 we developed the following:

- A standard template that could be completed by any member of staff using the Situation, Background, Assessment/Analysis, Recommendation (SBAR) headings that were already in use for Bluelight alerts. These help to share information in a concise way.

- Created the #allofusimprove learning template in both a Word document and an electronic format, accessible through the learning from experience intranet pages

- Created a central inbox for examples to be sent to learninglibrary@swyt.nhs.uk

- Created a shared network drive folder K:\#allofusimprove to be used as a 'library' for our learning examples. All staff can access the folder to view content. We can share links to content, either individual case studies or to themed content with others.

- Developed processes to manage the inbox and learning library folder content.

We have asked staff to:

- Identify opportunities to share learning from experience. This could be from learning from good practice, or where changes have been made for improvement.

- Talk with managers about ideas for #allofusimprove learning library.

- Complete the #allofusimprove learning template. Try to keep to one page. Ask someone to read it who doesn't know the situation. Think about what you'd tell a colleague verbally?

- Share examples locally with those around you who will be able to learn from your experience. E.g. share directly with your team, send it to similar teams across the Trust, share with your governance group. It is a good idea to add where you are sharing it on the document.

- Share examples with learninglibrary@swyt.nhs.uk where colleagues will store the example by theme in the shared network folder K:\#allofusimprove for wider themed learning. This is available to everyone.

Following the pilot of this work, in 2019/20, we will:

- Promote the learning library to encourage content from business delivery units, specialist advisors, and corporate teams.

- Strengthen the governance structures around the management of the content.

- Review how the content can be shared further.

What next?

The quality initiatives in the WELL- LED domain which we will undertake in 2019/20 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 are actively involved in quality improvement initiatives and continue to develop the framework for learning lessons.

Annexes

Annex 1 Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
ADHD	**ADHD** stands for **attention deficit hyperactivity disorder**. It is a medical condition. A person with ADHD has differences in brain development and brain activity that affect attention, the ability to sit still, and self-control.
Are you afraid to go home tonight?	The '**Are you afraid to go home tonight?**' initiative has been developed within the Safeguarding Team as a way of encouraging those who may be at risk of abuse or potential danger, to be able to alert a staff member who will act on their behalf. This was developed as an additional initiative in the understanding that some victims are subject to extreme control which limits their ability to seek help and protection without the knowledge of the perpetrator.
ASC	**Autism Spectrum Condition** (ASC) is a lifelong disability that affects how someone sees the world, processes information, and relates to other people
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.
CHPPD	**Care hours per patient day:** a national programme of work that compares the care hours per patient day required to deliver safer care in a team..
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 organizing 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
DOHSC	**Department of Health & Social Care:** The Government body responsible for delivering a fast, fair, convenient and high quality health service in England.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS
IAPT	**Improving Access to Psychological Therapies** is a National Health Service initiative to provide more psychotherapy to the general population
ICS	In an **integrated care system**, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
i-hub	**i-hub** is an online tool that helps us to connect, share, discuss, develop and spread ideas so that we can continuously innovate, improve and transform. It is a place to start conversations, vote, blog and tap in to resources and other parts of the system
IG	**Information Governance** ensures necessary safeguards for, and appropriate use of, patient and personal information.
Human Trafficking	***Human trafficking*** is an act of recruiting, harbouring, transporting, providing or obtaining a person for domestic servitude, forced marriage, organ removal, child sexual exploitation, sexual exploitation, begging or drug trafficking through force, fraud or coercion. The act of trafficking is directly linked to behaviour that seeks to harm and exploit both children and adults. Often, perpetrators of serious

	crime in relation to any of the above, can be disrupted, caught or prosecuted for human trafficking more easily than the crime they are intending to commit.
Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organization or of a particular activity in which it engages.
Making Safeguarding Personal'	The Care Act (2014) guidance (2015) refers to '**Making Safeguarding Personal'**. 'Making Safeguarding Personal means, it should be person led and outcome focused. It engages the person in a conversation about how best to response to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety
MSK	A **musculoskeletal (MSK)** disorder is any injury, disease or problem with your muscles, bones or joints. Muscle and joint problems are the biggest cause of work absence and physical disability in the UK.
NHS change model	The **change model**, originally developed in 2012, provides a useful organising framework for sustainable change and transformation that delivers real benefits for patients and the public. It was created to support health and care to adopt a shared approach to leading change and transformation.
NHS digital	**NHS Digital** is the trading name of the Health and Social Care Information Centre, which is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service.
NHSI	**NHS Improvement** is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
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
NMP	**Non-medical prescribing** is undertaken by a health professional who is not a doctor. ... Nurses, pharmacists and other health professionals, such as radiographers, who prescribe are highly skilled in their specialist area.
NRLS	**The National Reporting and Learning System (NRLS)** is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially.
POMH	**Prescribing Observatory for Mental Health:** The Prescribing Observatory for Mental Health (POMH-UK) is a national initiative to improve the quality of prescribing practice in mental health services through audit-based quality improvement programmes
SJR	The **structured judgment review** (SJR) review methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgment to be made that is reproducible.
SOF	**The Single Oversight Framework (SOF)** sets out how NHSI oversee NHS trusts and NHS foundation trusts, using one consistent approach. It helps NHSI to determine the type and level of support that Trusts need to meet these requirements.
SPA	**Single Point of Access (SPA**) provides a single route to obtain Urgent advice.
SystmOne	The electronic service user record system that is used in within out Trust .

Annex 2: Statements from our stakeholders

Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee – South West Yorkshire Partnership NHS Foundation Trust Quality Account 2018/2019

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.

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.

It is difficult for the Committee to make comment on particular areas of the Quality Account when it is still in draft. However, the Trust is to be commended for producing a narrative that makes sense to local citizens and that shows where the Trust is making progress but also identifies areas of required improvement.

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 experience of patients is a well-accepted marker of quality. The Committee therefore 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. The commitment to continue with a focus on transitions and access to CHAMS is also welcome.

The Committee supports the Trust's priority for improving physical healthcare for people with mental illness, particularly promoting health among people with severe mental illness. Members note the measures to routinely undertake a physical health assessment and treatment for people with serious mental illness and learning disability. The Committee supports the continued emphasis by the Trust in this area.

Members firmly believe that pressure ulcer prevention is a fundamental part of ensuring high quality patient care, promotion of patient safety and health service efficiency. It is therefore pleasing to see a significant reduction in relation to new pressure ulcers that are attributable to the Trust's care and are avoidable.

In relation to the 2018 NHS staff survey, the Committee notes the Trust's indicator of staff satisfaction with the quality of work and care they are able to deliver is below the national average. Similarly the staff friends and family test indicated that only 58% of staff would recommend the service as a place to work, again below the national average. The Committee therefore welcomes the Trust's priority for 2019/20 to make

the organisation a great place to work and the continued emphasis on the Workforce Strategy's strategic aim of improving staff well-being, resilience and engagement. There is compelling evidence that highly engaged employees are more likely to deliver high-quality care, are healthier and happier, with lower sickness rates and lower staff turnover – all of which will effectively contribute to the Trust's quality goals.

The Committee supports the framework for the Trust's quality priorities which are 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.

Overall the Committee believes that the Quality Account presents a balanced and representative picture of the quality of services provided by the Trust.

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.

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) 2018/19 Quality account statement.

Thank you for providing the South West Yorkshire Partnership Foundation Trust (SWYPFT) Quality Account 2018/19 for comment. The Quality Account has been shared with members of the Clinical Commissioning Groups who attend the SWYPFT Quality Board and their comments have been 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.

We are pleased to see the positive performance in relation to the Quality Priorities for 2018/19 and the clear focus on patient safety for the coming year, we look forward to working with The Trust to achieve the priorities set out for 2019/20:

- Improve health so that we deliver our role in integrated care in every place we operate
- Improve care with our reports or ratings in every service visited by the CQC
- Deliver our financial targets with improved use of resources
- Make the Trust a great place to work

It is encouraging to see the open and transparent way in which the Care Quality Commission findings are described in the Account and the ongoing plans to complete the improvement work required.

As commissioners we welcomed the opportunity to be involved in some of the quality monitoring visits within the Trust, however, the Quality Account would have been strengthened with some inclusion of the findings and actions agreed following the outcome of the visits.

It is encouraging to see the positive outcomes and measurable reduction in harm as a result of the Sign up to Safety programme. We must also note the work on the Learning from Death programme, it is positive to see that the Trust has a process in place to identify cases which require a review, is identifying themes and learning in order to make improvements; we note that this work will continue over the coming year and welcome the opportunity for commissioners to continue to support this process.

It is positive to see the trust is embracing an open and honest culture in developing further the Freedom to Speak up Guardian Network, and note the honesty in the CQC findings that staff were unaware of the role. We understand from the Quality monitoring visit that has since been addressed and staff are much more aware of this role.

We commend the Trust in its successful transition to SystmOne across inpatient and community services, and are pleased to see the plan has begun to share records with Primary Care and will continue to develop in eventually including patient access to records.

It is really encouraging to read about the Nursing and Allied Health Professional (AHP) Strategy and how both strategies are being used to develop pride and enthusiasm in the workforce and ultimately improve outcomes for patients, though we note your honesty in that objective being some way off achievement.

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.

Statement from Healthwatch Wakefield
Healthwatch Wakefield on the Quality Account of South West Yorkshire Partnership NHS Foundation Trust Comments for Publication

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 2018/2019. 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.

<u>Overall Summary</u>

The draft document that was presented to Healthwatch Wakefield for review is well designed and comprehensive. We particularly like the summary of performance against 2018/19 priorities which is then followed by a section with further detail for those who need it. However, we feel that, overall, the Quality Account is a very 'corporate' style document and doesn't give the impression that the Trust is patient centred, one that includes the voice of the patients and carers. There is minimal reference to asking service users to help measure, input on, or judge the outcomes. In future years we would therefore recommend a more public friendly version of the report wherever possible.

Additionally, 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 the Trust take at least the same approach.

Nevertheless, there is evidence of strong performance against most of the priorities the Trust set for itself, and although some of the targets were missed, we are encouraged by the efforts already made, the future plans, and the dedication of the team to continue driving through improvements despite the continuing challenges in the healthcare macro and micro environments.

Performance against 2018/19 Quality Priorities

We are pleased to note that no results for any of the priorities for 2018/19 were rated 'Red' (goal failed) and it remains encouraging to note good performance in many other areas with 17 out of 20 rated 'Green' (goal achieved). This is an improvement on 2017/18 and we are delighted to see progress continuing to be made.

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 safeguarding developments. Again, we are pleased to see ongoing improvement on 2017/18.

It remains hugely encouraging to see good performance in safer staffing fill rates, however we would continue to welcome continued and ongoing improvements relating to all areas within the safety domain.

Quality Domain: Effective

It is again good to see a strong performance in this domain compared to 2017/18, and it is heartening to see that four out of the five objectives were achieved, with the other being partially completed. We would therefore like to see completion of this final objective relating to policy and procedures under the new governance process, but we would also encourage further improvements in the review and implementation of relevant NICE guidance. We note that there are still a number of benchmarks to be set and Healthwatch Wakefield would like to see these in place as soon as possible.

Quality Domain: Caring

Again, it is heartening to see that four out of the five objectives were achieved, with the other being partially completed, Staff, Friends and Family Test (FFT) results missing their target, but remaining stable compared

to 2017/18. Nevertheless it is great to see a strong performance in relation to FFT results from patients, especially CAMHS, which has demonstrated considerable improvement compared to last year. There is however still work to be done here and we urge the Trust not to rest on their laurels.

Quality Domain: Responsive

Two out of the three 2017/18 objectives were achieved, whilst the result of the third was not available at the time of writing. Healthwatch Wakefield are encouraged to see completion of the planned Unity Centre developments, as well as participation in the regional integrated care system, and look forward to seeing the benefits of these revised initiatives over time.

Quality Domain: Well Led

We are pleased to see good results in relation to the quality improvement toolkit and the lessons learned framework, and hope that continued improvements in this area will reflect well in upcoming CQC inspections.

Quality Priorities for 2019/20

The priorities detailed in the Quality Account 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 2019/20.

The forward priorities have again been clustered against CQC quality domains (Safe, Effective, Caring, Responsive and Well Led) and a total of 14 areas have been prioritised. Healthwatch Wakefield is encouraged to note that many priorities from 2018/19 have been retained for 2019/20. We will be happy to continue to support the Trust in achieving continuous improvement in any way we can throughout the year.

Healthwatch Wakefield commends the Trust on its performance in delivering quality healthcare services to the people of Wakefield District and surrounds, and we look forward to continuing to support and work with the Trust to help ensure continuous improvements are sustained.

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 2018/19 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 2018 to March 2019
    - papers relating to Quality reported to the Board over the period April 2018 to March 2019
    - feedback from commissioners dated 21.5.19
    - feedback from local Health watch organisations dated 22.5.19
    - feedback from Overview and Scrutiny Committee dated 16.5.19
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018 (Q1), Oct 2018 (Q2), Dec 2018 (Q3) and March 2019 (Q4).
    - The national community mental health patient survey 2018
    - The national staff survey 2019
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 21.5.19
    - CQC Inspection report dated July 2018
- 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 23 May 2019 Chair

Date 23 May 2019 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 2019 (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 2019, 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 2019 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:

- board minutes for the period April 2018 to March 2019;
- papers relating to quality reported to the board over the period April 2018 to March 2019;
- feedback from Commissioners, dated 21/05/2019;
- feedback from local Healthwatch organisations, dated 22/05/2019;
- feedback from Overview and Scrutiny Committee, dated 16/05/2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018 (Q1), Oct 2018 (Q2), and Dec 2018 (Q3);
- the national community mental health patient survey 2018;
- the national staff survey 2019;
- Care Quality Commission inspection report, dated July 2018; and

- the Head of Internal Audit's annual opinion over the trust's control environment, dated 21/05/2019.

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.

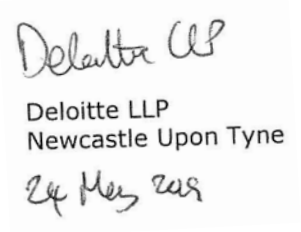
Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South West Yorkshire Partnership NHS Foundation Trust.

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 2019:

- 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 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.



Data entered below will be used throughout the workbook:

Trust name:	South West Yorkshire Partnership NHS Foundation Trust
This year	2018/19
Last year	2017/18
This year ended	31 March 2019
Last year ended	31 March 2018
This year commencing:	1 April 2018

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 23 May 2019

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; and

- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed……  ……..…..
Rob Webster Chief Executive Date 23 May 2019

Signed……  ……..…..
Mark Brooks Director of Finance Date 23 May 2019

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 2019 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 40.

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 were: *Valuation of provisions; and* *Property Valuations*
Materiality	The materiality that we used for the group financial statements was £4.50m 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 revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care is no longer considered key audit matters. There are two new key audit matters in the year being valuation of provisions and property valuations.

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.

In the current year the key audit matter in relation to revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care is no longer a key audit matter as there is unlikely to be an incentive to fraudulently recognise revenue due to the block contract nature of the Trust.

Valuation of Provisions are noted to be a new key audit matter in the current year because discussions with management indicated significant judgements regarded the recognition and valuation of the provisions.

Property Valuations are noted to be a new key audit matter in the current year because the Trust has undertaken a full estates revaluation and has implemented a new MEAV-AS design.

Valuation of Provisions

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 the valuation of provisions (2018/19 £7.7m 2017/18 £6.5M) due to: • The judgemental nature of estimating the value of provisions and recognition in line with IAS 37, including any releases to expenditure. Provisions included within the financial statements mainly relate to redundancy provisions (2018/19 £3.7m 2017/18 £3.6M). Details of the Group's provisions, are shown in note 25 to the financial statements. Valuation of Provisions are noted to be a new key audit matter in the current year because discussions with management indicated significant judgements regarding the recognition and valuation of the provisions.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over recognition and valuation of the provisions balance. We obtained evidence that the provisions have been recognised in accordance with IAS 37 and continue to require recognition. We reviewed the provisions recognised in the prior year and derecognised in the year to assess whether that the circumstances which gave rise to the provision have changed sufficiently to require derecognition. We tested the calculation of the provision and challenged any material estimates or judgements inherent in the valuation by performing detailed testing in line with the recognition criteria of IAS 37.
Key observations	We consider the valuation of provisions to be appropriate as at 31 March 2019.

Property Valuation

Key audit matter description	The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £99.7m (2017/18 £123.4m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. As detailed in note 1.7, Accounting Policies, the Group has reassessed a number of valuation assumptions in the current year, including the MEA assumptions used in the valuation. The net valuation movement on the Group's estate shown in note 12 is an impairment of £26.6m. Property Valuations are noted to be a new key audit matter in the current year because the Trust has undertaken a full estates revaluation and has implemented a new MEAV-AS design.

How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties. We challenged the Group's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by reviewing the Group's Clinical Strategy, and critically evaluating whether the alternatives considered would be viable given the nature of the Group's activities. We assessed the appropriateness of the reduced floor areas the Group has used in calculating a Modern Equivalent Asset valuation by considering the detailed justification of the differences from the current estate, and how these compared to the layout of the Group's estate compared to a modern building. We tested the calculation of the provision and challenged any material estimates or judgements inherent in the valuation by performing detailed testing in line with the recognition criteria of IAS 37.
Key observations	We consider the valuation of property assets to be fairly stated as at 31 March 2019.

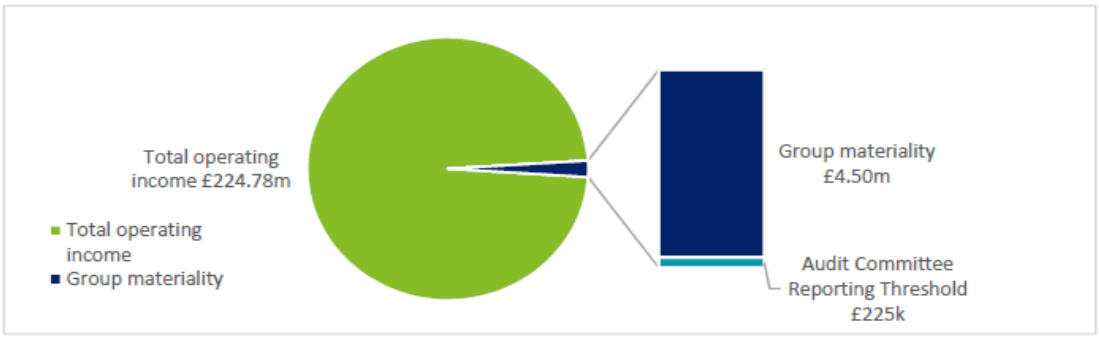
Our application of materiality

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	£4.50m (2017/18: £4.46m)
Basis for determining materiality	2% of Total Operating Income (2017/18: 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	£4.49m (2017/18: £4.45m)
Basis for determining materiality	2% of Total Operating Income (2017/18: 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 £225k (2017/18: £223k), 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!. 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 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 the opinions we have formed.

Paul Hewitson FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
Newcastle upon Tyne, United Kingdom

23-May-19

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2019

		Group		Trust	
	note	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000
Operating income from patient care activities	5	207,321	208,032	207,321	208,032
Other operating income	5	17,460	14,848	17,279	14,760
Operating Expenses	6	(230,959)	(215,451)	(230,784)	(215,246)
Operating surplus / (deficit)		**(6,178)**	**7,429**	**(6,184)**	**7,546**
Finance costs:					
Finance income	10	162	66	161	65
PDC Dividends payable		(3,156)	(3,393)	(3,156)	(3,393)
NET FINANCE COSTS		**(2,994)**	**(3,327)**	**(2,995)**	**(3,328)**
Gains/(losses) on disposal of assets	13	500	425	500	425
SURPLUS/(DEFICIT) FOR THE YEAR		**(8,672)**	**4,527**	**(8,679)**	**4,643**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	27	(14,707)	(1,719)	(14,707)	(1,719)
Revaluations	27	0	9,841	0	9,841
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(23,379)**	**12,649**	**(23,386)**	**12,765**

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 40 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2019	note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	14	108	231	108	231
Property, plant and equipment	15	99,737	123,419	99,737	123,419
Investment Property	16	160	160	160	160
Total non-current assets		**100,005**	**123,810**	**100,005**	**123,810**
Current assets					
Inventories	20	259	232	259	232
Trade and other receivables	21	10,785	8,132	10,787	8,134
Non-current assets for sale and assets in disposal groups	17	0	0	0	0
Cash and cash equivalents	22	28,371	27,108	27,823	26,559
Total current assets		**39,415**	**35,472**	**38,869**	**34,925**
Current liabilities					
Trade and other payables	23	(19,844)	(16,917)	(19,817)	(16,882)
Provisions	25	(3,939)	(3,377)	(3,939)	(3,377)
Other liabilities	23	(276)	(670)	(276)	(670)
Total current liabilities		**(24,059)**	**(20,964)**	**(24,032)**	**(20,929)**
Total assets less current liabilities		**115,361**	**138,318**	**114,842**	**137,806**
Non-current liabilities					
Provisions	25	(3,282)	(3,113)	(3,282)	(3,113)
Total assets employed		**112,079**	**135,205**	**111,560**	**134,693**
Financed by					
Taxpayers' equity					
Public Dividend Capital		44,222	44,015	44,222	44,015
Revaluation reserve	27	9,453	24,938	9,453	24,938
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		52,665	60,520	52,665	60,520
Others' equity					
Charitable fund reserves		519	512	0	0
Total taxpayers' and others' equity		**112,079**	**135,205**	**111,560**	**134,693**

The financial statements on pages 2 to 40 were approved by the Board of Directors and authorised for issue on the 21 May 2019 and signed on their behalf by:

Signed……

Rob Webster Chief Executive

Date 23 May 2019

GROUP STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	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 2018		44,015	24,938	5,220	60,520	134,693	512	135,205
Impact of implementing IFRS15 on 1 April 2018		0	0	0	0	0	0	0
Impact of implementing IFRS9 on 1 April 2018		0	0	0	46	46	0	46
Surplus for the year		0	0	0	(8,352)	(8,352)	(320)	(8,672)
Transfers between reserves		0	(389)	0	389	0	0	0
Impairments	12	0	(14,707)	0	0	(14,707)	0	(14,707)
Revaluations - property, plant and equipment	27	0	0	0	0	0	0	0
Transfer to retained earnings on disposal of assets	27	0	(389)	0	389	0	0	0
Public dividend capital received		207	0	0	0	207	0	207
Other reserve movements - charitable funds consolidation adjustment		0	0	0	(327)	(327)	327	0
Taxpayers' Equity at 31 March 2019		**44,222**	**9,453**	**5,220**	**52,665**	**111,560**	**519**	**112,079**

		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**

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 2018		44,015	24,938	5,220	60,520	134,693
Impact of implementing IFRS15 on 1 April 2018		0	0	0	0	0
Impact of implementing IFRS9 on 1 April 2018		0	0	0	46	46
Surplus for the year		0	0	0	(8,679)	(8,679)
Transfers between reserves		0	(389)	0	389	0
Impairments	12	0	(14,707)	0	0	(14,707)
Revaluations - property, plant and equipment	27	0	0	0	0	0
Transfer to retained earnings on disposal of assets	27	0	(389)	0	389	0
Public dividend capital received		207	0	0	0	207
Taxpayers' Equity at 31 March 2019		**44,222**	**9,453**	**5,220**	**52,665**	**111,560**

		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**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED		Group		Trust	
31 March 2019		**Year Ended 31 March 2019**	**Year Ended 31 March 2018**	**Year Ended 31 March 2019**	**Year Ended 31 March 2018**
	note	**£000**	**£000**	**£000**	**£000**
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		(6,178)	7,429	(6,184)	7,546
Operating surplus/(deficit)		**(6,178)**	**7,429**	**(6,184)**	**7,546**
Non-cash income and expense:					
Depreciation and amortisation	6	4,741	5,853	4,741	5,853
Net Impairments	6	11,856	(613)	11,856	(613)
Income recognised in respect of capital donations (cash and non-cash)		0	0	0	0
(Increase)/Decrease in receivables	21	(2,558)	516	(2,558)	539
(Increase)/Decrease in Inventories	20	(27)	(66)	(27)	(66)
Increase/(Decrease) in Trade and Other Payables	23	3,007	(1,355)	3,007	(1,355)
Increase/(Decrease) in Other Liabilities	23	(394)	(84)	(394)	(84)
Increase/(Decrease) in Provisions	25	731	(1,060)	731	(1,060)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		(8)	8	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**11,170**	**10,628**	**11,172**	**10,760**
Cash flows from investing activities					
Interest received	10	161	65	161	65
Purchase of intangible assets	14	0	(19)	0	(19)
Purchase of Property, Plant and Equipment		(8,367)	(10,019)	(8,367)	(10,019)
Sale of property, plant and equipment and Investment Property		1,296	2,486	1,296	2,486
NHS Charitable Funds - net cash flows from investing activities		1	1	0	0
Net cash generated from/(used in) investing activities		**(6,909)**	**(7,486)**	**(6,910)**	**(7,487)**
Cash flows from financing activities					
Public dividend capital received		207	350	207	350
PDC Dividend paid		(3,205)	(3,437)	(3,205)	(3,437)
Net cash generated from/(used in) financing activities		**(2,998)**	**(3,087)**	**(2,998)**	**(3,087)**
Increase/(decrease) in cash and cash equivalents		**1,263**	**55**	**1,264**	**186**
Cash and Cash equivalents at 1 April		27,108	27,053	26,559	26,373
Cash and Cash equivalents at 31 March		**28,371**	**27,108**	**27,823**	**26,559**

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 DHSC GAM 2018/19 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 1st April 2018 and 31st December 2018 and as a result the revaluation was recognised in these accounts. This has been reviewed as at 31st March 2019 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 2018 / 2019 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 transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

● As per paragraph 121 of the Standard, the Trust will not disclose information regarding performance obligations that forms part of a contract that has an original expected duration of one year or less:

● The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date:

● The Financial Reporting Manual ("FReM") has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregated effect of all contracts modified before the date of initial application.

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 in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Income from other revenue streams are assessed on a individual contract basis to ensure that the performance obligation has been met before recognising income.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is an Output method. Output methods recognise revenue on the basis of direct measurements of the value to the customer of the goods or services transferred to date, relative to the remaining goods or services promised under the contract. The Trust assesses the measure of performance completed to date.

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 2018/19 the periodic revaluation of estate has been completed by the District Valuer. This was a full revaluation which involved a physical inspection of each building. The Trust also reviewed and revised the MEA assumptions used within the valuation.

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 ("SCI") 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, 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 SCI. 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 SCI.

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 on-going 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 2018 / 2019.

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

Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques. The method used has the measurement adjusted to defer the difference between the fair value at initial recognition and the transaction price.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS9, and is determined at the time of recognition.

Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measure the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

The Trust has adopted a provision matrix based on historical loss experience, the calculation for this is based on the sales invoices raised in the financial year 2017/18. The Trust identified 3 main groups of debtors which are payroll/salary sacrifice, local council and other.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds , and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Notes to the Accounts - 1. Accounting Policies (Continued)

Financial liabilities
Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

Financial liabilities at fair value through profit and loss
Derivatives that are liabilities are subsequently measured at fair value though profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments thorough the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

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
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, EyUp!, 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 DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury Financial Reporting Manual adoption, with IFRS 16 being for implementation in 2019/20 and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases - effective 2020 / 2021
IFRS 17 Insurance Contracts - effective 2021 / 2022
IFRIC 23 Uncertainty over Income Tax Treatments - effective 2019 / 2020

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 2019.

2. Pooled budget

The Group & Trust has no pooled budgets.

3. Operating segments

The Group & Trust has a single operating segment, Healthcare, as reported through the Trust Board finance report.

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 2019 Total £000**	**Year Ended 31 March 2018 Total £000**
NHS England	25,383	24,874
Clinical commissioning groups	164,427	166,735
NHS Foundation Trusts	350	509
NHS Trusts	1,584	1,202
Local Authorities	7,533	8,349
Department of Health and Social Care	2,509	0
NHS Other	0	0
Non NHS: Other	5,535	6,363
Total income from activities	**207,321**	**208,032**

	Group & Trust	
5.2 Analysis of income from activities	**Year Ended 31 March 2019 Total £000**	**Year Ended 31 March 2018 Total £000**
Cost and volume contract income - Mental Health Services	806	560
Block Contract income - Mental Health Services	158,439	155,984
Clinical income for the secondary commissioning of mandatory services	5,792	5,636
Income from CCGs & NHS England - Community Services	31,947	35,756
Income from other sources - Community Services	7,731	8,745
Agenda for Change pay award central funding	2,509	0
Other clinical income	97	1,351
Total income from activities	**207,321**	**208,032**

5.3 Other Operating Income	**Group Year Ended 31 March 2019 Total £000**	**Group Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2019 Total £000**	**Trust Year Ended 31 March 2018 Total £000**
Other operating income recognised in accordance with IFRS 15				
Research and development (IFRS 15)	230	0	230	0
Education and training (excluding notional apprenticeship levy income)	3,645	3,463	3,645	3,463
Provider sustainability fund / Sustainability and transformation Fund incor	4,741	2,881	4,741	2,881
Income in respect of staff costs where accounted for on a gross basis	2,748	2,743	2,748	2,743
Other (recognised in accordance with IFRS 15)*	5,605	5,435	5,605	5,435
Other operating income recognised in accordance with other standards				
Research and development (non-IFRS 15)	0	195	0	195
Education and training - notional income from apprenticeship fund	310	43	310	43
NHS Charitable Funds : Incoming Resources excluding investment income	181	88	0	0
Total other operating income	**17,460**	**14,848**	**17,279**	**14,760**
Total Operating Income	**224,781**	**222,880**	**224,600**	**222,792**

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

*** Analysis of Other Operating Income (recognised in accordance with IFRS 15): Other**	**Group Year Ended 31 March 2019 Total £000**	**Group Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2019 Total £000**	**Trust Year Ended 31 March 2018 Total £000**
Estates recharges	122	224	122	224
IT recharges	135	122	135	122
Staff contributions to employee benefit schemes	2,970	2,631	2,970	2,631
Catering	285	259	285	259
Property rentals	82	81	82	81
Other	2,011	2,118	2,011	2,118
Total	**5,605**	**5,435**	**5,605**	**5,435**

5.4 Income from activities from Commissioner Requested Services and all other services	**Group Year Ended 31 March 2019 Total £000**	**Group Year Ended 31 March 2018 Total £000**	**Trust Year Ended 31 March 2019 Total £000**	**Trust Year Ended 31 March 2018 Total £000**
Income from Commissioner Requested Services	207,321	208,032	207,321	208,032
Income from non-Commissioner Requested Services	17,460	14,848	17,279	14,760
Total Income	**224,781**	**222,880**	**224,600**	**222,792**

5.5 Operating lease income

The Group & Trust earned no income from operating leases in 2018/19 or in 2017/18.

5.6 Additional information on contract revenue (IFRS 15) recognised in the period

	Group & Trust Total 2018/19 £000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	431
Revenue recognised in the reporting period from performance obligations satisfied (or partially satisfied) in previous periods (e.g. changes in transaction price)	188

5.7 Transaction price allocated to remaining performance obligations (i.e revenue not recognised this year)

	Group & Trust Total 31 March 2019 £000
Revenue from contracts entered into as at by the end of the period and expected to be recognised:	
within one year	8,929
after one year not later than five years	11,891
after five years	0
Total	**20,820**

6 Operating Expenses

6.1 Operating Expenses	**Note**	**Group Year Ended 31 March 2019 £000**	**Group Year Ended 31 March 2018 £000**	**Trust Year Ended 31 March 2019 £000**	**Trust Year Ended 31 March 2018 £000**	
Purchase of healthcare from NHS and DHSC bodies		397	251	397	251	
Purchase of healthcare from non-NHS and non-DHSC bodies		5,949	5,640	5,949	5,640	
Staff and executive directors costs		167,907	166,335	167,603	166,287	
Non-executive directors		141	145	141	145	
Supplies and services - clinical (excluding drug costs)		4,827	4,239	4,827	4,239	
Supplies and services - general		2,668	3,246	2,668	3,246	
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)		3,371	3,720	3,371	3,720	
Consultancy		105	265	105	265	
Establishment		6,495	7,922	6,495	7,922	*
Premises - Business rates payable to Local Authorities		1,108	987	1,108	987	
Premises - other		7,434	7,483	7,434	7,483	
Transport (Business travel only)		2,250	147	2,250	147	*
Transport (other)		1,281	321	1,281	321	*
Depreciation on property, plant and equipment	15	4,618	5,709	4,618	5,709	
Amortisation on intangible assets	14	123	144	123	144	
Net Impairments of property, plant and equipment	12	11,856	(613)	11,856	(613)	
Movement in credit loss allowance: contract receivables/assets	21.2	(9)	23	(9)	23	
Movement in credit loss allowance: all other receivables & investments		0		0		
Change in provisions discount rate	25	(22)	18	(22)	18	
Audit services- statutory audit		62	62	62	62	
Other auditor remuneration	6.2	0	0	0	0	
Audit services - charitable fund accounts		1	1	0	0	
Internal audit - non-staff		78	98	78	98	
Clinical negligence - amounts payable to NHS Resolution (premium)	25	619	476	619	476	
Legal fees		46	219	46	219	
Insurance		253	251	253	251	
Education and training - non-staff		639	752	639	752	
Education and training - notional expenditure funded from apprenticeship fund		310	43	310	43	
Operating lease expenditure (net)	9.1	6,300	6,474	6,300	6,474	
Early retirements - non-staff		34	(22)	34	(22)	
Redundancy costs - staff costs		157	60	157	60	
Car parking and security		51	24	51	24	
Hospitality		23	35	23	35	
Other losses and special payments - non-staff	36	14	51	14	51	
Other services (e.g. external payroll)		6	3	6	3	
Other NHS charitable fund resources expended		197	292	0	0	
Other		1,670	650	1,997	786	
Total Operating Expenses		**230,959**	**215,451**	**230,784**	**215,246**	

* In 2018/19 the trust reviewed its allocation of expenditure within Operating expenses and moved expenditure classified within establishment to travel. The 2017/18 comparators have not been amended.

6.2 Other Audit Remuneration	Group & Trust	
	Year Ended 31 March 2019	Year Ended 31 March 2018
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	0
Total	**0**	**0**

6.3 Auditor Liability

The auditors liability for 2018/19 and 2017/18 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 2018/19 or in 2017/18.

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 2019			Trust Year Ended 31 March 2019		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	133,301	118,703	14,598	133,301	118,703	14,598
Social Security Costs	11,590	10,457	1,133	11,590	10,457	1,133
Apprenticeship levy	571	511	60	571	511	60
Pension costs - defined contribution plans employers contributions to NHS Pensions	15,898	15,091	807	15,898	15,091	807
Termination benefits	157	157	0	157	157	0
Agency/contract staff	6,459	0	6,459	6,459	0	6,459
NHS charitable funds staff	304	304	0	0	0	0
Employee benefits expense	**168,280**	**145,223**	**23,057**	**167,976**	**144,919**	**23,057**
Of which are capitalised as part of assets	216	216	0	216	216	0
Operating expenditure analysed as:						
Employee expenses - staff & executive directors	167,907	144,850	23,057	167,603	144,546	23,057
Redundancy	157	157		157	157	
Total Employee benefits excl. capitalised costs	**168,064**	**145,007**	**23,057**	**167,760**	**144,703**	**23,057**

	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**

As included within the salaries and wages information above, the Trust made payments in 2018/19 and 2017/18 of greater than £100k to the following staff groups:

	Year Ended 31 March 2019	Year Ended 31 March 2018
Medical Consultant	58	53
Other Doctor	10	12
Director / Chief Executive	8	6
Clinical Psychologist	0	1
Total	**76**	**72**

7. Employee costs and numbers (continued)

7.2 Average number of people employed	**Group**			**Trust**		
	Year Ended 31 March 2019			**Year Ended 31 March 2019**		
	Total	**Permanently Employed**	**Other**	**Total**	**Permanently Employed**	**Other**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Medical and dental	184	163	21	184	163	21
Administration and estates	1,022	988	34	1,022	988	34
Healthcare assistants and other support staff	769	591	178	769	591	178
Nursing, midwifery and health visiting staff	1,284	1,209	75	1,284	1,209	75
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	764	744	20	764	744	20
Social care staff	16	16	0	16	16	0
Other	0	0	0	0	0	0
Total	**4,039**	**3,711**	**328**	**4,039**	**3,711**	**328**
Of which are engaged on capital projects	**4**	**4**	**0**	**4**	**4**	**0**

	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**

Unit of measure is whole time equivalent (WTE).

7.3 Staff sickness absence	**Group & Trust**	
	Year Ended 31 March 2019	**Year Ended 31 March 2018**
	Number	**Number**
Total days lost	43,665	45,920
Total staff years	3,764	3,902
Average working days lost	11.6	11.8

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 2018/19 January 2018 - December 2018.

7.4 Early retirements due to ill health

During the year there were 4 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health (7 during 2017/18). The estimated additional pension liabilities of these ill-health retirements is £349k (2017/18 £600k). 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

6 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 2019

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	0	0	0	0	**0**	**0**
£10,001 - £25,000	2	36	0	0	**2**	**36**
£25,001 - £50,000	3	112	0	0	**3**	**112**
£50,001 - £100,000	0	0	0	0	**0**	**0**
£100,001 - £150,000	0	0	0	0	**0**	**0**
£150,001 - £200,000	1	160	0	0	**1**	**160**
Total number of exit packages by type	**6**	**308**	**0**	**0**	**6**	**308**

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**

Exit Packages: other (non-compulsory) departure payments	Payments agreed 31 March 2019	Total value of agreements 31 March 2019	Payments agreed 31 March 2018	Total value of agreements 31 March 2018
	Number	£'000	Number	£'000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	3	34
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	**0**	**0**	**3**	**34**
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 2019, is based on the valuation data as at 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2018/19 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 £81k (2017/18 £30k). 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 28 lease properties, all with different Landlords. The rental periods range from 1 to 18 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 2019 £000**	**Year Ended 31 March 2018 £000**
Minimum lease payments	6,300	6,474
	6,300	**6,474**

Future minimum lease payments due	**Year Ended 31 March 2019 £000**	**Year Ended 31 March 2018 £000**
Payable:		
Not later than one year	4,948	5,109
Between one and five years	13,029	13,573
After five years	20,752	22,325
Total	**38,729**	**41,007**

10. Finance Income	Group Year Ended 31 March 2019 £000	Group Year Ended 31 March 2018 £000	Trust Year Ended 31 March 2019 £000	Trust Year Ended 31 March 2018 £000
Interest on bank accounts	161	65	161	65
NHS Charitable funds: investment income	1	1	0	0
Total	**162**	**66**	**161**	**65**

The Group & Trust has no interest on impaired financial assets included in finance income in 2018/19 or in 2017/18.

11. Finance Costs - interest expense

The Group & Trust incurred no finance costs in 2018/19 or in 2017/18.

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

	Group & Trust					
	31 March 2019			31 March 2018		
	Net Impairment £000	Impairments £000	Reversals £000	Net Impairment £000	Impairments £000	Reversals £000
Impairments charged to operating surplus / deficit:						
Changes in market price	11,856	12,734	(878)	(613)	2,020	(2,633)
Total Impairments charged to operating surplus / deficit	**11,856**	**12,734**	**(878)**	**(613)**	**2,020**	**(2,633)**
Total net impairments charged to revaluation reserve	14,707	14,861	(154)	1,719	1,719	0
Total impairments and (reversals)	**26,563**	**27,595**	**(1,032)**	**1,106**	**3,739**	**(2,633)**

13. Gains/losses on disposal/derecognition of assets

	Group & Trust	
	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000
Gains on disposal/derecognition of property, plant and equipment	665	88
Gains on disposal/derecognition of investment properties	0	0
Gain on disposal/derecognition of assets held for sale	0	347
Losses on disposal/derecognition of other property, plant and equipment	(165)	(20)
Losses on disposal/derecognition of investment properties	0	0
Total gains/(losses) on disposal of assets	**500**	**415**
Fair value gains/(losses) on investment properties	0	10
Total other gains/(losses)	**500**	**425**

14 Intangible assets

14.1 Intangible assets 2018/19	Group & Trust	
	Total	**Software licences (purchased)**
	£000	**£000**
Gross cost at 1st April 2018	**1,939**	1,939
Additions - purchased	**0**	0
Disposals / derecognition	**0**	0
Gross Cost at 31 March 2019	**1,939**	**1,939**
Amortisation at 1st April 2018	**1,708**	1,708
Provided during the year	**123**	123
Disposals / derecognition	**0**	0
Amortisation at 31 March 2019	**1,831**	**1,831**
Net book value		
NBV - Purchased at 31 March 2019	**108**	108
NBV total at 31 March 2019	**108**	**108**

14.2 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**

14.3 Intangible assets

Intangible Assets are all purchased software licences and are depreciated over the life of the licence which is currently no more than 4 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 2019

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 2018	**133,627**	17,000	97,782	4,101	4,990	662	7,272	1,820
Additions - purchased	**8,295**	0	1,402	4,236	129	0	2,242	286
Impairments charged to operating expenses (note 12)	**(11,143)**	(4,666)	(6,477)	0	0	0	0	0
Impairments charged to the revaluation reserve (note 12)	**(7,671)**	(2,735)	(4,936)	0	0	0	0	0
Reversal of impairments credited to operating expenses	**878**	0	878	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	**154**	7	147	0	0	0	0	0
Reclassifications	**0**	0	7,284	(7,284)	0	0	0	0
Revaluations	**(1,382)**	0	(1,382)	0	0	0	0	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**(1,204)**	(255)	(424)	0	(372)	(76)	(77)	0
Cost or Valuation at 31 March 2019	**121,554**	**9,351**	**94,274**	**1,053**	**4,747**	**586**	**9,437**	**2,106**
Accumulated depreciation at 1st April 2018	**10,208**	65	648	0	3,820	613	4,034	1,028
Provided during the year	**4,618**	0	3,112	0	252	23	1,072	159
Impairments charged to operating expenses(note 12)	**1,591**	0	1,591	0	0	0	0	0
Impairments charged to the revaluation reserve	**7,190**	0	7,190	0	0	0	0	0
Reversal of impairments credited to operating expenses (note	**0**	0	0	0	0	0	0	0
Revaluations	**(1,382)**	0	(1,382)	0	0	0	0	0
Reclassified as held for sale	**0**	0	0	0	0	0	0	0
Disposals	**(408)**	0	(41)	0	(249)	(73)	(45)	0
Accumulated depreciation at 31 March 2019	**21,817**	**65**	**11,118**	**0**	**3,823**	**563**	**5,061**	**1,187**
Net book value								
Net book value at 31 March 2019								
NBV - Owned at 31 March 2019	**99,737**	9,286	83,156	1,053	924	23	4,376	919
NBV - Donated at 31 March 2019	**0**	0	0	0	0	0	0	0
NBV total at 31 March 2019	**99,737**	**9,286**	**83,156**	**1,053**	**924**	**23**	**4,376**	**919**

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.

On the 1st April 2018 the Trust reviewed the MEA methodology this led to an impairment loss, a further revaluation on the 31st December 2018 led to some reversals on the loss due to an increased BCIS index.

15.2 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
Reversal of impairments credited to operating income (note 12	**(101)**	0	(101)	0	0	0	0	0
Revaluations	**(2,633)**	(5)	(2,628)	0	0	0	0	0
Reclassifications	**(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	0 792
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.

15.3 Economic Lives of Property, Plant and Equipment

	Group & Trust	
	Min Life Years	**Max Life Years**
Land		
Buildings excluding dwellings	0	89
Plant & Machinery	0	10
Transport Equipment	0	2
Information Technology	0	5
Furniture & Fittings	0	10

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 2019	31 March 2018
	£000	£000
At Carrying Value		
Balance at Beginning of Period	160	150
Fair value gains (taken to I&E)	0	10
Disposals	0	0
Balance at End of Period	**160**	**160**

* 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 2018/19 (£0k in 2017/18).

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 2018/19.

Summary Statement of Financial Activities

	31 March 2019	31 March 2018
	£000	£000
Total Incoming Resources	508	225
Staff Costs	(304)	(48)
Resources expended with bodies outside the NHS	(197)	(293)
Net movement in funds	**7**	**(116)**

Summary Statement of Financial Position	31 March 2019	31 March 2018
	£000	£000
Cash and cash equivalents	548	549
Trade and other receivables	0	0
Trade and other payables	(29)	(37)
Net Assets	**519**	**512**
Other restricted income funds	325	363
Unrestricted income funds	194	149
Total Charitable Funds	**519**	**512**

Restricted income funds include the linked charities of Creative Minds, Mental Health Museum and Sprit in Mind. The majority of the restricted funds relate to Creative Minds (£287k).

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 2018	**0**	**0**	**0**
Plus assets classified as available for sale in the year	0	0	0
Less assets sold in year	0	0	0
NBV of non-current assets for sale at 31 March 2019	**0**	**0**	**0**

	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**

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 2018/19 or in 2017/18.

18. Other assets

The Group & Trust has no other assets in 2018/19 or in 2017/18.

19. Other Financial Assets

The Group & Trust has no other financial assets in 2018/19 or in 2017/18.

20. Inventories

20.1. Inventory Movements

	Group & Trust		
	Total	**Drugs**	**Other**
	£000	**£000**	**£000**
Carrying Value at 1 April 2018	**232**	**167**	**65**
Additions	3,186	2,792	394
Inventories recognised in expenses	(3,159)	(2,773)	(386)
Carrying Value at 31 March 2019	**259**	**186**	**73**

	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**

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 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Current				
Contract receivables (IFRS 15): invoiced	4,024	0	4,024	0
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	5,138	0	5,138	0
Trade receivables (comparative only)	0	3,195	0	3,195
Accrued income (comparative only)	0	3,704	0	3,704
Allowance for impaired contract receivables / assets	(66)	(121)	(66)	(121)
Allowance for impaired other receivables	0	0	0	0
Prepayments	1,416	1,171	1,416	1,171
PDC dividend receivable	63	14	63	14
VAT receivable	210	159	210	159
Other receivables	0	10	2	12
NHS Charitable funds: Trade and other receivables	0	0	0	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**10,785**	**8,132**	**10,787**	**8,134**
Of which receivable from NHS and DHSC group bodies:				
Current	8,017	4,157	8,017	4,157

The Group & Trust have no non current trade and other receivables as at 31 March 2019 (£0 (zero) as at 31 March 2018).

21.2 Allowances for credit losses (doubtful debts)	Group & Trust		
	Total 2018/19 £000	Contract receivables and contract assets 2018/19 £000	All other receivables 2018/19 £000
Allowance for credit losses at 1 April 2018 - brought forward (before IFRS9 and IFRS15 implementation)	121	0	121
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018 balanc	(46)	75	(121)
New allowances arising	25	25	0
Reversals of allowances	(34)	(34)	0
Utilisation of allowances	0	0	0
Balance at 31 March	**66**	**66**	**0**
Loss/(gain) recognised in expenditure	**(9)**	(9)	0

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 Finance lease receivables

The Group & Trust has no finance lease receivables.

22. Cash and cash equivalents	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Balance at 1st April	**27,108**	**27,053**	**26,559**	**26,373**
Net change in year	1,263	55	1,264	186
Balance at 31 March	**28,371**	**27,108**	**27,823**	**26,559**
Broken down into:				
Cash at commercial banks and in hand	656	632	108	83
Cash with the Government Banking Service	27,715	26,476	27,715	26,476
Cash and cash equivalents as in statement of financial position	**28,371**	**27,108**	**27,823**	**26,559**
Cash and cash equivalents as in statement of cash flows	**28,371**	**27,108**	**27,823**	**26,559**

Third party assets (Patient Monies) held by the Trust

	Group & Trust	
	31 March 2019 £000	31 March 2018 £000
Bank balances	284	257
Monies on deposit	105	88
Total third party assets	**389**	**345**

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 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Current				
Trade payables	4,725	4,093	4,725	4,093
Capital payables (including capital accruals)	1,070	1,142	1,070	1,142
Accruals	8,020	5,798	8,020	5,798
Social Security costs	2,282	2,235	2,282	2,235
Other taxes payable	1,424	1,392	1,424	1,392
Other payables	2,296	2,222	2,296	2,222
PDC dividend payable	0	0	0	0
NHS Charitable funds: Trade and other payables	27	35	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**19,844**	**16,917**	**19,817**	**16,882**
Of which payable to NHS and DHSC group bodies				
Current	2,538	1,655	2,538	1,655

The Group & Trust had no non-current trade and other payables as at 31 March 2019 (£0 (zero) as at 31 March 2018).

23.2 Early retirements detail included in NHS payables

The Group & Trust had no early retirement costs included in payables as at 31 March 2019 (£0 (zero) as at 31 March 2018).

23.3 Other liabilities

	Group & Trust	
	31 March 2019 £000	**31 March 2018 £000**
Current		
Deferred Income: contract liability (IFRS 15)	276	670
Deferred Income: other (non-IFRS 15)	0	0
TOTAL OTHER CURRENT LIABILITIES	**276**	**670**
Non-current		
Deferred Income: contract liability (IFRS 15)	0	0
Deferred Income: other (non-IFRS 15)	0	0
TOTAL OTHER NON CURRENT LIABILITIES	**0**	**0**

23.4 Other Financial Liabilities

The Group & Trust had no other financial liabilities as at 31 March 2019 (£0 (zero) as at 31 March 2018).

24. Borrowings

The Group & Trust had no borrowings as at 31 March 2019 (£0 (zero) as at 31 March 2018).

25. Provisions

	Group & Trust Current		Group & Trust Non-current	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Pensions - Early departure costs	56	55	467	495
Pensions - Injury Benefits	60	59	907	939
Legal claims	58	45	1,032	689
Redundancy	3,186	3,218	376	490
Other	579	0	500	500
Total	**3,939**	**3,377**	**3,282**	**3,113**

	Group & Trust					
	Total	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2018	6,490	550	998	734	3,708	500
Change in the discount rate	(22)	(5)	(17)	0	0	0
Arising during the year	4,708	34	46	451	3,598	579
Utilised during the year (accruals)	(29)	(14)	(15)	0	0	0
Utilised during the year (cash)	(443)	(42)	(45)	(95)	(261)	0
Reversed unused	(3,483)	0	0	0	(3,483)	0
At 31 March 2019	**7,221**	**523**	**967**	**1,090**	**3,562**	**1,079**
Expected timing of cash flows:						
Not later than one year;	3,939	56	60	58	3,186	579
Later than one year and not later than five years;	2,370	222	240	1,032	376	500
Later than five years (see note 31.3).	912	245	667	0	0	0
Total	**7,221**	**523**	**967**	**1,090**	**3,562**	**1,079**

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 £3.6m, relates to approximately 64 posts during 2019/2020 and a further 10 redundancies during 2020/2021. 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.

Injury benefits - These 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 - This consists of 2 provisions one is a £500k provision in relation to a potential fine relating to Information Governance breaches and the other £579k relates to a HMRC VAT payment.

£1,308K is included in the provisions of the NHS Resolution at 31 March 2019 (£2,741k at 31 March 2018) 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 2019 (none as at 31 March 2018).

26.2 Contingent assets

The Group & Trust had 1 contingent asset as at 31 March 2019 (1 as at 31 March 2018).

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	**Revaluation Reserve - property, plant and equipment**
	£000	**£000**
As at 1 April 2018	**24,938**	**24,938**
Impairments	(14,707)	(14,707)
Revaluations	0	0
Transfers to other reserves	(389)	(389)
Asset disposals	(389)	(389)
Revaluation reserve at 31 March 2019	**9,453**	**9,453**
	£000	**£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**

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 2019	**31 March 2018**
	£000	**£000**
Property, plant and equipment	969	5,249
Intangible assets	0	0
Total	**969**	**5,249**

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

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparatives have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

31.1 Financial assets	Group Total £000	Group Held at amortised cost £000	Trust Total £000	Trust Held at amortised cost £000
Assets as per SoFP				
Receivables (excluding non financial asses) - with DHSC bodies	**7,954**	7,954	**7,954**	7,954
Receivables (excluding non financial asses) - with other bodies bodies	**1,142**	1,142	**1,142**	1,142
Cash and cash equivalents	**27,823**	27,823	**27,823**	27,823
NHS Charitable funds: financial assets	**548**	548	**0**	0
Total at 31 March 2019	**37,467**	**37,467**	**36,919**	**36,919**
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**

There is no difference between carrying amount and fair value

31.2 Financial liabilities	Group Total £000	Group Held at amortised cost £000	Trust Total £000	Trust Held at amortised cost £000
Liabilities as per SoFP				
Trade and other payables (excluding non-financial liabilities) - with DHSC bodies	**1,968**	1,968	**1,968**	1,968
Trade and other payables (excluding non-financial liabilities) - with other bodies	**11,995**	11,995	**11,995**	11,995
IAS 37 provisions which are financial liabilities	**7,221**	7,221	**7,221**	7,221
NHS Charitable funds: financial liabilities	**27**	27	**0**	0
Total at 31 March 2019	**21,211**	**21,211**	**21,184**	**21,184**
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**

31.3 Maturity of Financial liabilities	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
In one year or less	18,979	14,517	18,979	14,517
In more than one year but not more than two years	0	648	0	648
In more than two years but not more than five years	1,320	1,483	1,320	1,483
In more than five years (see note 25)	912	982	912	982
Total	**21,211**	**17,630**	**21,211**	**17,630**

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 2019 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 (Integrated Care System)

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, Chair, Invesco Pensions Ltd, Director, Invesco UK Ltd, Chair, PRISM, Governor Calderdale College, Magistrate and Chair, NHS Pension Board.

Charlotte Dyson, Deputy Chair / Senior Independent 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.

Erfana Mahmood, Non Executive Director. Non-Executive Director, Chorley and District Building Society. Non-Executive Director, Plexus / Omega Housing, part of Mears Group PLC. Sister - employee for guide-line telephone helpline for Mind in Bradford.

Kate Quail, Non Executive Director. Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.

Sam Young, Non Executive Director. Owner / Director of ISAY Consulting Limited. Non Executive Director, Great Places Housing Group.

Tim Breedon, Director of Nursing and Quality / Deputy Chief Executive. Son works in the Trust's Occupational Health Service as a Registered Nurse.

Alan Davis, Director Human Resources, Organisational Development and Estates. Spouse is employed by Blackpool Teaching Hospitals NHS FT as the Managing Director, NHS North West Leadership Academy.

Carol Harris, Director of Operations. 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 2018/19		
Department of Health and Social Care	2,579	0
Other NHS Bodies	202,829	10,181
Other	0	0
Total	**205,408**	**10,181**

	Income	**Expenditure**
Value of transactions with other related parties in 2017/18	**£000**	**£000**
Department of Health and Social Care	88	0
Other NHS Bodies	202,083	12,138
Other	0	0
Total	**202,171**	**12,138**

35.2 Related Party Balances

	Group & Trust	
	Receivables	**Payables**
	£000	**£000**
Value of transactions with other related parties in 2018/19		
Department of Health and Social Care	0	0
Other NHS Bodies	7,955	2,428
Other	0	0
Total	**7,955**	**2,428**

	Receivables	**Payables**
Value of transactions with other related parties in 2017/18	**£000**	**£000**
Department of Health and Social Care	0	0
Other NHS Bodies	4,141	1,656
Other	0	0
Total	**4,141**	**1,656**

36. Losses and Special Payments

	Group & Trust			
	Year Ended 31 March 2019 Total number of cases Numbers	Year Ended 31 March 2019 Total value of cases £000s	Year Ended 31 March 2018 Total number of cases Numbers	Year Ended 31 March 2018 Total value of cases £000s
Losses:				
1. Losses of cash due to:				
a. theft, fraud etc.	0	0	0	0
b. overpayment of salaries etc.	0	0	0	0
c. other causes	7	0	4	0
2. Fruitless payments and constructive losses	0	0	0	0
3. Bad debts and claims abandoned	18	9	17	10
4. Damages to buildings, property etc. (including stores losses)	0	0	0	0
Total Losses	**25**	**9**	**21**	**10**
Special Payments				
5. Compensation under legal obligation	2	3	1	1
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments				
a. loss of personal effects	36	2	38	4
d. other negligence and injury	3	2	0	0
e. other employment payments	0	0	2	32
g. other	5	1	2	4
8. Special severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0
Total Special Payments	**46**	**8**	**43**	**41**
Total Losses and Special Payments	**71**	**17**	**64**	**51**

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 2018/19 (0 (zero) in 2017/18)

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.

39. Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Reassessment of allowances for credit losses under the expected loss model resulted in a £46k decrease in the carrying value of receivables.

Impact of IFRS 9 on financial assets as at 1 April 2018	**Group Total £000**	**Trust Total £000**
Carrying values under IAS 39 as at 31 March 2018		
Financial assets held at amortised cost (loans and receivables)	33,898	33,349
Total at 31 March 2018 under IAS 39	**33,898**	**33,349**
Carrying values under IFRS 9 as at 1 April 2018 (after applying both IFRS 9 and IFRS 15)		
Financial assets measured at amortised cost	33,944	33,395
Total at 1 April 2018 under IFRS 9	**33,944**	**33,395**
Effect of implementation of IFRS 9 (and IFRS 15) as at 1 April 2018:		
Total change in carrying value	**46**	**46**
Made up of changes as a result of:		
Other measurement changes (not as a result of changing measurement category) under IFRS 9	46	46

Impact of IFRS 9 on financial liabilities as at 1 April 2018	**Group Total £000**	**Trust Total £000**
Carrying values under IAS 39 as at 31 March 2018		
Financial liabilities at amortised cost	17,630	17,630
Total at 31 March 2018 under IAS 39	**17,630**	**17,630**
Carrying values under IFRS 9 as at 1 April 2018 (after applying both IFRS 9 and IFRS 15)		
Financial liabilities measured at amortised cost	17,630	17,630
Total at 1 April 2018 under IFRS 9	**17,630**	**17,630**
Effect of implementation of IFRS 9 as at 1 April 2018		
Total change in carrying value	**0**	**0**

Impact of IFRS 9 implementation on allowance for doubtful debts as at 1 April 2018	**Group & Trust Total £000**
Allowance for doubtful debts (credit losses) under IAS 39 as at 31 March 2018	
Trade and other receivables - with other bodies	121
Total at 31 March 2018 under IAS 39	**121**
Allowance for doubtful debts (credit losses) under IFRS 9 as at 1 April 2018	
Contract receivables and contract assets - with other bodies	75
Total at 1 April 2018 under IFRS 9	**75**
Change in loss allowance arising from application of IFRS 9	**(46)**

40. Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

There has been no impact from the initial application of IFRS 15.