Council of Governors Meeting

23 April 2015

11.00 – 13.30

(Pre-meeting for Governors only commences at 10.00)

Overline Lounge, American Express Community Stadium,
Village Way, Brighton, BN1 9BL

For copies of papers, queries or further information, contact:
Rebecca Huth, Rebecca.huth@sussexpartnership.nhs.uk
Telephone 01903 843033
# MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC

To be held in the Overline Lounge, American Express Community Stadium, Village Way, Brighton, BN1 9BL

Thursday 23 April 2015 at 11.00am

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<td>CG 12/15</td>
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<td>11.01</td>
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<td>To receive any declarations of interest</td>
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<td>11.02</td>
<td>CG 14/15</td>
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<td>11.05</td>
<td>CG 15/15</td>
<td>Chief Executive’s Report</td>
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<td>Colm Donaghy, Chief Executive</td>
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<td>11.10</td>
<td>CG 16/15</td>
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<td>Emma Fordham, Lead Governor</td>
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<td>11.20</td>
<td>CG 17.1/15</td>
<td>Update Report on Adult Services</td>
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<td>Lorraine Reid, Managing Director of Adult Services</td>
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<td>11.30</td>
<td>CG 17.2/15</td>
<td>Update Report on Specialist Services</td>
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<td>Simone Button, Interim Managing Director of Specialist Services</td>
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<td>11.40</td>
<td>CG 17.3/15</td>
<td>Finance and Performance Report</td>
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<td>Sally Flint, Executive Director of Finance and Performance</td>
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<td>11.50</td>
<td>CG 17.4/15</td>
<td>Patient Experience Report</td>
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<td>Vincent Badu, Strategic Director of Social Care and Partnerships</td>
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<tr>
<td>12.00</td>
<td>CG 17.5/15</td>
<td>Audit of Letters to GPs (copied to service users)</td>
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<td>Dr Tim Ojo, Executive Medical Director</td>
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<td>12.10</td>
<td>CG 18.1/15</td>
<td>Report from the Membership Committee</td>
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<td>Karen Braysher, Committee Chair &amp; Governor</td>
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<td>12.15</td>
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<td>Report from the Quality Committee</td>
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<td>Melloney Poole, Non-Executive Director</td>
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<td>Time</td>
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<td>12.20</td>
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<td>Report from the Mental Health Act Committee&lt;br&gt;Melloney Poole, Non-Executive Director</td>
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<td>12.25</td>
<td>CG 18.4/15</td>
<td>Report from Finance &amp; Investment Committee&lt;br&gt;Richard Bayley, Non-Executive Director</td>
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<td>12.30</td>
<td>CG 18.5/15</td>
<td>Report from the People Committee&lt;br&gt;Diana Marsland, Non-Executive Director</td>
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<td>12.35</td>
<td>CG 18.6/15</td>
<td>Report from Audit Committee&lt;br&gt;Tim Masters, Non-Executive Director</td>
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<td>Internal Audit Plan 2014/15&lt;br&gt;Nick Atkinson, Baker Tilly Risk Advisory Services LLP</td>
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<td>12.50</td>
<td>CG 18.7/15</td>
<td>Report from Charitable Funds (Heads On)&lt;br&gt;Diana Marsland, Non-Executive Director</td>
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<td>12.55</td>
<td>CG 18.8/15</td>
<td>Report from the Nomination and Remuneration Committee&lt;br&gt;Caroline Armitage, Chair</td>
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### STRATEGY

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<td>13.00</td>
<td>CG 19.1/15</td>
<td>Strategic Review (Our 2020 Vision)&lt;br&gt;Sam Allen, Director of Strategy and Improvement</td>
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<td>13.10</td>
<td>CG 19.2/15</td>
<td>Draft Quality Account&lt;br&gt;Kay Macdonald, Clinical Academic Director</td>
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<tr>
<td>13.20</td>
<td>CG 19.3/15</td>
<td>Council Development&lt;br&gt;Peter Lee, Head of Corporate Governance</td>
<td>Verbal</td>
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<tr>
<td>13.30</td>
<td>CG 20/15</td>
<td>Questions or comments from members of the public&lt;br&gt;(Chair to be notified in advance of the meeting)</td>
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| CG 21/15 | Any Other Business |       |

**Date of next meeting:**

27 July 2015  
11.00 – 13.30  
Overline Lounge, American Express Community Stadium

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<td>13.35</td>
<td>CG 22/15</td>
<td>To adopt the motion:&lt;br&gt;“That representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”&lt;br&gt;(Section 1(2) Public Bodies (Admission to Meetings) Act 1960)</td>
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**NB** Those present at the meeting should be aware that their name will be issued in the notes of this meeting which may be released to members of the public on request.
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Council of Governors meeting held in public on Monday 19 January 2015 at 11.00am in the Overline Lounge at the American Express Community Stadium, Village Way, Brighton, BN1 9BL

Present:
John Bacon, Chair, Sussex Partnership NHS Foundation Trust (Chair)

Elected Governors
Andrew Voyle, Service User Governor, East Sussex
Giles Wright, Service User Governor, Brighton and Hove
Jane Tatum, Service User Governor, East Sussex
Nic Allen Service User Governor, West Sussex
Paul Burris, Service User Governor, West Sussex
Elizabeth Hall, Service User, West Sussex
Karen Braysher, Service User Governor, Brighton & Hove
Phyllida De Salis, General Public Governor, East Sussex
Scott Hunt, General Public Governor, East Sussex
Mick Burtenshaw, General Public Governor, West Sussex
Martin Jeremiah, Carer Governor
Adam Churcher, Staff Governor
Dr Jose Belda, Staff Governor
Emma Fordham, Staff Governor
Denise D'Souza, Appointed Governor
Michael Chambers, Governor

Appointed Governors:
David Standing, Chief Executive of Sussex Central YMCA
Andy Winter, Chief Executive of Brighton Housing Trust
Graham Taylor, Headteacher, West Kent Health Needs Education Service

In attendance
Colm Donaghy, Chief Executive
Tim Ojo, Executive Medical Director
Tim Masters, Non-Executive Director
Melloney Poole, Non-Executive Director
Sue Morris, Executive Director of Corporate Services
Sally Flint, Executive Director of Finance & Performance
Simone Button, Managing Director, Specialist Services (in the interim)
Lorraine Reid, Adult Services, (in the interim)
Sam Allen, Director of Strategy and Improvement
Helen Greatorex, Executive Director of Nursing
Peter Lee, Head of Corporate Governance
Carol Damerell, Diary Manager to Chief Executive (minutes)
**Apologies for absence**
Diana Marsland, Non-Executive Director  
Professor Gordon Ferns, Non-Executive Director  
Kay Macdonald, Clinical Academic Director  
Christopher Masters, Carer Governor  
Richard Bayley, Non-Executive Director  
Giles Adams, South Coast Ambulance Service NHS Foundation Trust

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<th>CG 01/15</th>
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<td>John Bacon welcomed everyone to the meeting and stated that Tim Masters would be chairing the Private Council of Governor’s meeting. John also welcomed Carol Damereill as Minute taker for the meeting.</td>
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<tr>
<th>CG 02/15</th>
<th>To receive any declarations of interest</th>
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<td>No declarations of interest were received.</td>
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<th>Minutes of the meeting held on 20 October 2014, action points and matters arising</th>
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<tr>
<td>Page 1:</td>
<td>Helen Greatorex stated her attendance at the meeting held on 20 October was not recorded.</td>
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<td>Emma Fordham, Staff Governor, pointed out that on the attendance list of the Minutes of the last meeting, it incorrectly recorded that Sarah Reynolds, Staff Governor attended the meeting.</td>
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<td>Page 8:</td>
<td>Martin Jeremiah queried the 10 hours peer support on each adult acute ward across West Sussex, and whether this referred to 3 sites rather than each? Martin needed clarification regarding the 10 hours.</td>
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<td><strong>Action:</strong> Helen Greatorex will amend to reflect the correct regarding level of support provided.</td>
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<td>Colm Donaghy provided feedback on the CQC inspection that took place during the w/c 12 January 2015. Colm stated there were also some unannounced inspections. 100 inspectors were involved. The CQC felt they were made very welcome within the organisation; staff were open and engaged with the CQC in a positive way. Adam Churcher was congratulated for his work in preparation for the CQC inspection. The inspection ran very smoothly, however, there were some concerns which will be reported when the final report is received. The first draft report will be available in roughly 6 weeks’ time and this will be shared with the Trust for factual accuracy. The Trust will be given 2 weeks to check for factual accuracy. A Quality summit will then be held where we and external stakeholders will be invited, at which we will be presented with the final report.</td>
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<td>Mick Burtenshaw asked how the ratings were determined. Colm advised there are 11 core services, 5 domains, and each domain and core service will be rated. The organisation will then be given a rating of either: Inadequate; Requires Improvement; Good; or Outstanding.</td>
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John Bacon reminded council members that a fuller discussion on the CQC inspection will take place at the next COG meeting when we should have had the draft report.

**Strategic review:**
Colm advised that internal and public workshops have taken place and have had good engagement. Sam Allen will give an update today.

**Finance:** While it will be a challenge, Colm remains confident that we will be at break-even at the end of the year. Sally will provide and update at this meeting.

Bed pressures arose over the Christmas period. Sally will highlight areas later in the meeting.

Andrew Voyce asked Colm for his feedback on innovation.

Colm responded that there were a number of ways we have taken this forward:

- Staff recognition awards were identified - application was made for some of the awards;
- Agreed to take part in "Listening into Action" which is designed to highlight improvement and spread across the organisation;
- Identified champions within the organisation in order to drive improvement, we are one of 10 trusts to take part in April next year.

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**Finance and Performance Report**

*Sally Flint, Executive Director of Finance and Performance*

Sally discussed the key points of the Finance and Performance report. Sally talked members through the key issues in relation to the current deficit and how we would recover that position. Sally stated that assurance was given to the CQC last week that the quality of care had not been impacted by the Trust’s current financial position. The Trust’s Performance Dashboard was also discussed, highlighting that the source of the key performance indicators was now stated on the front of the dashboards, in response to the actions arising from the last meeting.

Following on from the last meeting Sally Flint and Dave West had met with Karen Braysher to discuss the access target from long term service users in Brighton. Sally thanked Karen for a helpful discussion in terms of better understanding the importance of this access target.

Karen stated it was good to meet with Sally and Dave West; as a service user Karen said it was acceptable to have a 2 weeks’ wait however, a month is excessive. John advised this was useful information to take back to the relevant colleagues.

Simone referred to the data and quality issues, and pointed out the data is actually better than presented in the report. Simone stated with regards to referral to assessment, there was a definite improvement. She also stated that there were data quality issues, which meant that the report is not currently reflecting the information that is captured manually. Hampshire has issues around resourcing, additional resource in place to address this. The Trust is now undertaking a similar process in Hampshire as undertaken in Kent to address demand and capacity issues. We need to be clear around the waiting list process which has some challenges which are being addressed with the CCGs.

Contract in Hampshire: The Trust has responded to this tender and has been shortlisted for this service. However the tender has recently been put on hold because the CCGs have identified additional resource. Simone explained it was good news that
more resource was going into Hampshire as there is a significant increase in referrals.

Giles Wright referred to point 3.3 on agency staff with regard to the high risk of using agency staff. Giles stated he had noted the comment reflected for some time now and requested clarification on how the problem of agency staff is being addressed. Giles also noted the overspend on drugs had decreased.

Martin Jeremiah also raised his concerns on Agency staff and stated that the plans / actions had not appeared to make a difference and felt the reason was due to the general recruitment problem. Martin suggested Sue Esser join the next meeting in order to obtain data behind the recruitment issues enabling to get to the source of the problem.

John gave an overview of Agency spend issues and verified the problem was not unique to us but a national NHS issue. John stated it was the Trusts’ top priority and a major concern, however there was no one simple solution.

Sue Morris clarified we have made some inroads however three areas remain challenges for us:

- Focus on Child and Young Persons services in Kent and difficulty in recruitment.
- Dementia wards, regarding the amount of observations required to support patients. We need to look at why and what it means for staffing levels.
- Langley Green Hospital and North West Sussex Community services - we struggle to compete with London rates of pay. Sue reported that the Trust is looking to offer equivalent pay to what staff would earn in London. Sue also stated that Crawley has been identified as one of the top 10 towns in the country which had reported a significant increase in housing costs.

Sue felt that Giles’s point regarding retention was also very important, stating that currently the same number of staff were leaving the Trust as coming into post. The key work force challenges coming up in the next 5 years relates to Band 5 nursing staff.

Sue reminded the Council that we are at the end of sourcing staff from our local pool, and will be looking elsewhere with regards to recruitment.

Mick Burtenshaw suggested the committee set up a task group to offer ideas to address the recruitment issues.

John confirmed this would be helpful and more time could be spent on this at such a task group.

**Action – staff recruitment and retention workshop to be arranged (Peter Lee and Sue Morris to lead)**

Denise D’Souza confirmed that Brighton area experiences the same issues and it was difficult to recruit with higher living costs. She also felt the City Council is not as sighted on the impact of delayed transfers of care, and mental health is being treated with the same priority in the system as the Acute Trust.

JB stated the points were well made, and reiterated that the length of stays are in relation to moving patients onto their next stage of care.

Giles Adams asked if the Trust had thought of setting up their own Agency instead of using bank staff. He stated there is one in East and one in the West. He suggested staff could be retained who were familiar to the Trust. This could reduce nursing agency problems. John said this could be very useful.
Karen Braysher asked whether the Trust had considered having staff living in quarters around hospitals, as St Francis hospital had many years ago.

Andy Winter commented with regards to social housing it was worth looking at, but felt this was not a problem for the Trust but more of a National issue.

In respect to the agency issue Sally Flint stated it was a National issue and Monitor had concerns about it. It was agreed that it would be useful to have a Governors Forum to give some further thought to this problem.

Report from the Finance & Investment Committee  
(Richard Bayley, Non-Executive Director)

It was noted that the Report from the Finance & Investment Committee was included in the Finance and Performance Report and also that Christopher Master, the governor representative on the Committee also shared the Board Summary report from the Committee with Council members.

CG 05.1/15  
Patient Experience/Complaints Report  
Helen Greatorex, Executive Director of Nursing and Quality & Vincent Badu, Strategic Director of Social Care and Partnerships

Helen Greatorex presented her report.

The purpose of this paper provides an update to the Council of Governors on work under way to develop monthly reporting on the patient experience feedback we receive across all services and the quality of improvement put in place as a result. Report to be presented at the Trust Board.

Response so far from carers: 85% positive, few negative feedback.

Mick Burtenshaw raised concerns regarding the Friends & Family Test (FTT) and felt it wasn’t good to use that as our benchmark.

Mick Burtenshaw questioned as to whether all the Hospitals have Tablets for the Family & Friends Test, and asked why they can’t complete an independent questionnaire and queried whether this would be a fairer way to undertake the FFT?

Martin Jeremiah verified the Tablet was used by his daughter on the ward for the survey and felt it was a good exercise as it decreases staff involvement.

Giles Wright felt patient surveys were not used as a bench marking tool.

Graham Taylor queried how much this is used in service and asked whether this was used universally.

Simone Button stated this was introduced across Kent.

Colm verified this is one of the methodologies the Trust uses, although there is other work and a range of initiatives going on, and reminded members that we don’t depend on one source of feedback.

Giles Wright raised various issues on formats of feedback for FTT.

John Bacon suggested that Giles speak to the individual Executive Director outside this meeting.

Denise D'Souza queried the triangulation with regards to safeguarding and queried
how that intelligence will be collected.

John Bacon advised to discuss this outside this meeting.

**Report from the Quality Committee**  
*Melloney Poole, Non-Executive Director*

Melloney Poole gave the Council an overview of the specific areas looked at by the Quality Committee. The Committee met on Thursday 6 November 2014 and the Minutes of the meeting are available to all board members on Board Pad. Melloney also outlined the duties of the committee as reflected in her paper. Melloney stated the committee examined in depth quality issues with regards to quality and patient safety. Melloney said she would appreciate feedback from the Council of Governors. The report is taken to the Public Trust Board meetings.

Jane Tatum felt there was a lot overlap in the committees and stated that information on access to an Advocate was not up to date.

Melloney confirmed that access to an Advocate was being looked into by Quality Committee and it was important that the information should be available on all wards.

Colm informed this should be integrated for first time next month through the Executive Assurance Committee.

Giles Wright asked if the Trust has any competent data available on waiting times for advocacy in Brighton & Hove, and what the realistic chance would be to obtain an appointment in the next month.

John Bacon stated this information was not to hand immediately.

Sam Allen agreed to look at who commissions Advocacy Independent Service and to look into Giles’s question regarding the waiting times.

Andy Winter stated that the Quality Committee report was really helpful and should be used as a model for board committee reports.

Sue Morris confirmed a new committee started in 2013, focusing on workforce, and Sue Esser, People Director, was appointed in November 2013. This was a move to help better focus on what improves staff engagement. An improvement plan is in place; Listening into Action project which has support of the Executive team. We are interested in focussing on information to give a better understanding of staff environment, etc.

Giles Wright pointed out he had submitted a Freedom of Information (FOI) request and asked if a governor submits an FOI are the timescales still observed? John Bacon confirmed that a response to an FOI is 20 working days.

**CG 05.2/15**  
**Care Plan & Medication Audit Proposal**  
*(Tim Ojo, Executive Medical Director & Helen Greatorex, Executive Director of Nursing andty)*

An issue was raised regarding GP letters. Tim Ojo advised that samples have been looked at and he reported there was clear evidence of problems across the Trust and this is trying to be rectified.

John Bacon confirmed that the offer stands for the governors to work with Tim Ojo to give their input prior to meeting.
Phyllida De Salis recommended service users’ input with regards to medication.

Karen Braysher put forward a suggestion of a “care plan passport” which would hold a record of patients’ details and medications they used.

John Bacon asked Tim Ojo and Kay MacDonald to look into this suggestion.

**CG 05.3/15**  
**Report from the People Committee**  
*(Sue Morris, Executive Director of Corporate Services)*

Sue Morris presented her report from the People Committee – no issues raised by members.

**CG 05.4/15**  
**Report from the Audit Committee (Re-appointment of External Auditors)**  
*(Tim Masters, Non-Executive Director)*

Tim Masters confirmed that a summary report from the Audit Committee is produced for the public section of the Trust board meeting and Committee meetings are observed by two governors, who feed back to the Audit Committee.

Tim outlined the purpose and membership of the committee and what they cover; the Audit Committee work for the plan for the year; the summary of the work of the internal auditors and local counter fraud service and the summary of the work of the external auditors all of which are detailed in the report.

Tim stated central to the role are finances and accountability and the committee test the effectiveness of this by engaging with internal auditors.

Tim asked the members if there were any questions or concerns.

Giles Wright asked if a governor comes across an incidence where a patient is at risk, who should this be reported to? Giles was provided with details of the Trust’s Local Counter Fraud Manager. At this point Giles stated he did not wish to elaborate on this issue.

John Bacon asked Giles to take up this query with Helen Greatorex.

Jane Tatum questioned the processing of Agency invoices and the lack of attempt to look at potential populations on the wards and queried whether this process would change.

Tim Masters stated that Agency was an issue and has been a problem for Trust. The issue the Committee has focused on is the cost of agency; the Committee engaged with our internal auditors.

Jane asked about the issue of people working for the trust and for an agency. In cost terms she felt it is an expense for the Trust and welcomed the overlapping work of the committee and was pleased to hear Colm has a plan in place to triangulate issues.

John Bacon felt the point was well made, however stipulated that we can’t judge in totality what is happening via one route.

Martin Jeremiah confirmed priorities had been set for next audit plan.

Michael Chambers asked whether there was consideration on alternatives for appointing external auditors.
Tim Masters confirmed there was an option to extend the PWC contract for a further 3 years and stated it takes a period of time for an audit company to get to understand the Trust. Tim felt it was important we have an efficient audit. Tim informed that it was his last year as audit Chair, and that it would be an appropriate time to consider a new tender audit, by the time the new Chair is in post.

Tim stated that although it is the Council of Governors’ decision as to who the external auditor would be, his recommendation is to continue with PWC and start the tender process in the summer. John Bacon agreed that it was for the Council of Governors to decide when they wanted to tender for external auditors.

A discussion was held in general, and around the timescales / leading time to go to tender. Options were either going out to market to tender or agree with Tim Masters’ recommendation on extending PWC for this year.

Sally Flint stated she would outline a timetable on audit committee next week setting out plans for year end. Retendering at this stage of the year would take around three months and therefore would not be in time for the 2014/15 year end.

Andy Winter asked for clarification with regards to new auditors from April 2015 or 2016, and felt the members should not make a hasty decision.

John Bacon’s recommendation was to allow PWC to carry out the audit on 2014/15 accounts, and to put a process in place to re-tender external audit for 2015/16 accounts.

John Bacon asked the Council of Governors to vote on whether they were in favour of allowing PWC to be re-appointed as external auditors for 2014/15 and to put a process in place to re-tender external audit for 2015/16 accounts.

Decision – all voted in favour, save for two members who voted against. On this basis PWC’s contract is extended to conduct the 2015.16 audit.

**CG 06/15 Update Report on Specialist Services**
*(Simone Button, Interim Managing Director of Specialist Services)*

Simone Button pointed out the hard work the team were engaged with at the CQC inspection over the last week.

Simone mentioned the service plans will be completed by the end of January and stated there is involvement of the Non-Executive Directors and staff, and ideas are built on by service users.

Simone gave an update on tenders - Specialist services; Substance misuse service the Trust have lost the tender in Brighton & Hove and said there will be a new service provided by the end of the year.

Lewes prison – Trust has been successful in gaining a longer term contract, (primary care and MH prison)

Hampshire CAMHS tender is on hold and has been suspended. Waiting to hear from CCGs regarding the implications. For Sussex Partnership it creates challenges.

Andy Winter raised the question regarding Substance Misuse Service in Brighton & Hove and asked what process was utilised for reviewing why a Tender was not won by the Trust.
Sam Allen discussed the tender process and outlined the specific requirements set out; i.e. on bidding, and what the Trust has regarding resources, capabilities, etc.

Andy Winter stated that Clinicians should be involved and more open to feedback/approach.

Giles Wright referred to Substance Misuse staff being lost to a different management due to the Trust losing the Tender.

John Bacon reminded that all staff were TUPE'D over, and the Trust had no choice and explained that if we lose the contract you lose the staff to another organisation.

### CG 06/15
**Update Report on Adult Services**  
*(Lorraine Reid, Managing Director of Adult Services)*

Lorraine Reid presented her report.

Elizabeth Hall questioned the increase in overseas visitors.

Lorraine explained this was an odd spike for the time of year and thought it may be due to people travelling from overseas, who then became ill whilst on holiday.

### CG 07/15
**Strategic Review Update**  
*(Sam Allen, Director of Strategy and Improvement)*

Sam Allen highlighted the points around ‘our 2020 vision’ and the themes captured in the joint board/council review day which took place recently.

Sam stated there was ongoing work from the Directors and discussions with staff and public engagement.

Sam confirmed a first Vision workshop was held on Friday. Reports from this has been inspiring and a new vision and purpose statement is being developed.

Karen Brayser asked for an update on MSK.

Sam Allen confirmed there are two new contracts: Brighton & Hove and stated that Crawley and Horsham went live on 1\textsuperscript{st} October; East Sussex went live on 1\textsuperscript{st} January with full service by April this year.

### CG 08/15
**Governors Activities**  
*(Mick Burtenshaw, Lead Governor)*

Mick Burtenshaw presented the report and advised a brief session was held with the CQC and reported it was a good and well attended meeting. There was also networking between governors, Non-executive directors (NEDs) and Trust Board members. Mick pointed out it was the first opportunity for members to meet Colm Donaghy. Mick also said the governors were involved in the recruitment process to appoint the new Chair as well as the NED post.
## CG 08.1/15  Feedback from Development Day  
*(Mick Burtenshaw, Lead Governor)*

Mick Burtenshaw provided feedback from the Development day. Although there were some good ideas put forward, Mick stated it was poorly attended by governors. He emphasised the need to re-engage as a group.

Items discussed: Code of conduct; Website: Mick reported that a lot of information was out of date.

Mick pointed out that the Foundation Trust Governance Association is now the Foundation Trust Network (NHS Trust Providers). The website is under review.

Mike stated copies of Minutes from the Development day will be circulated to members and he would welcome any comments.

Giles Wright thanked John Bacon with regards to the improved timescale for receiving the papers for the Council of Governors meeting.

At this point Mick reminded the members that it was John Bacon’s last meeting as Chair and thanked John for the work he has done for the Trust which has been much appreciated by all. (A card on behalf of the members was presented to John by Martin Jeremiah).

John expressed his appreciation for the kind words and said although the Chairman’s job was not the easiest it was a good experience and wished his successor well.

## CG 08.2/15  Feedback from Membership Committee  
*(Karen Braysher, Committee Chair)*

Karen Braysher reported the Membership Committee met on 18th December 2014 and a discussion took place on how best to continue publicising.

As outlined in the report Karen stated the Committee had agreed that the possibility of holding events including musicians/film, service user band, etc to promote mental health and recovery may be a more successful way to engage with the public.

## CG 08.3/15  Council of Governor’s Meeting Venues  
*(Peter Lee, Head of Corporate Governance)*

Peter Lee reported that this was an action of the last meeting with regards to obtaining information on alternative venues to hold the Council of Governors meetings. The members were asked which venue they preferred.

The Amex seemed to be the preferred option and was voted to be the most pleasant venue.

Jane Tatum stipulated a venue would be suitable which is easily accessible. Jane felt Swandean would not be a suitable choice as parking could be a problem.

Sussex Cricket club was not easily accessible.

Denise D'Souza pointed out that it was important to have a venue that was “technology friendly”.

John Bacon asked the members to explore the various options and suggested his successor could take the venue options forward.
| CG 09/15 | Questions or comments from members of the public  
*(Chair to be notified in advance of the meeting)* |
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<td>No questions or comments were received from members of the public.</td>
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<tr>
<th>CG 10/15</th>
<th>Any Other Business</th>
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<td></td>
<td>Nic Allen raised the discussion on Trust targets. John Bacon suggested he has a discussion with Sally Flint and that Governors may want to discuss this at other meetings.</td>
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<td></td>
<td>Giles Wright asked if FOI's could be presented to the Governors, John Bacon confirmed this could be done.</td>
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| Date of next meeting:  
Monday 20 April 2015  
From 11.00am  
Overline Lounge, American Express Community Stadium |

| CG 11/15 | To adopt the motion:  
"That representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960). |

John Bacon, Chair, Sussex Partnership NHS Foundation Trust

*NB Those present at the meeting should be aware that their name will be published in the notes of this meeting which may be released to members of the public on request.*
### MATTERS ARISING: ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING HELD IN PUBLIC ON MONDAY 19 JANUARY 2015

<table>
<thead>
<tr>
<th>Date of Action</th>
<th>Action or Agenda Item</th>
<th>Min. No.</th>
<th>Action Points from previous meeting</th>
<th>Lead</th>
<th>Action Taken</th>
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<tr>
<td>19.01.2015</td>
<td>Action</td>
<td>CG 05/15</td>
<td>Staff Recruitment and Retention workshop to be arranged (Peter Lee and Sue Morris to lead)</td>
<td>Peter Lee and Sue Morris</td>
<td>Meeting took place on 23.03.2015</td>
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MANAGING DIRECTOR OF ADULT SERVICES REPORT

INTRODUCTION
This divisional leadership teams in adult services have been discussing the paper on Care Delivery Units (CDU). Sally Flint and I have been working with the divisions to finalise their plans for 2014/15. Teams are keen to move forward with a different and more local approach that has potential to be more engaging. We are also focusing on how to meet the financial challenges of the coming year in order to create the sort of headroom that is required to consider a sustainable five year plan. In effect this means that service directors are looking at ways to reduce the pressure on our inpatient services, focusing community teams and reducing spend on temporary staffing.

At the end of April, Ian Watling, who has been working in the service director role in Coastal West Sussex retires after forty years’ service in the NHS. Following a successful recruitment process which produced 20 applications for the post, I look forward to welcoming Jo Scott to my team. Jo is currently working in Kent, Children and Young People’s Services and brings her experience of demand and capacity modelling to the team. We will bid a fond farewell to Ian at the end of April, who has spent his entire career working in Sussex and has always been a strong advocate for recovery-oriented working, improving the experience of people who use services and their carers, promoting peer recovery and user involvement.

ACTION REQUIRED BY COUNCIL MEMBERS
Council members are invited to note the contents of the report and ask questions of the author.
Context

The pressures that have been covered in the media continue to affect our acute services; this is the usual pattern at this time of year and nationally there is a similar picture. In response we have developed an escalation policy that is designed to address the key issues, implemented a business continuity approach and will continue working in this mode until all the local pressures are resolved and people who need admission are being admitted to their local hospitals. It is my hope that many of the actions devised in this particular plan will become business as usual, reducing the need for escalation in the future. The volume of out of area placements has been reduced and generally we are more able to accommodate people locally, however this situation remains fragile and there is certainly no room for complacency. Current actions reach beyond the acute care pathway and involve community services. Teams are aware of their Duty of Candour responsibilities and cognisant of the need to work closely with people who use our services and their carers when an out of area admission is being considered. It is not surprising that the situation has given rise to media coverage and led some people to complain: people should expect to be treated in their own area and it is our ambition to achieve this, and respond more effectively to seasonal pressures.

Strategy

We are planning to promote the new operational leadership structure at an evening event and clinicians interested in taking up leadership responsibilities at any level in the organisation will be invited to attend. This is also a good opportunity to explore how Clinical Academic Groups (CAG) will support the local services as they become more autonomous; consistent care pathways linked to Payment by Results will be pivotal to the future success of the CDUs. CAGs provide opportunities for clinicians, who wish to get more involved in influencing how services are provided, but do not want to take up a formal leadership role, to get more involved.

Feedback from business planning workshops that Sally and I have been running indicates that teams are finding it useful to develop a framework in readiness for the CDU development process and that the process is engaging. I have also been working on plans to assign exec and non-executive directors to the divisions to support this work. These plans are being well received by commissioning colleagues who are keen to work within a more local approach and personal approach that enables a clinical dialogue about the key issues. The Leadership Conference in February provided a platform for sharing and engaging our staff and other key stakeholders in our ambitions.
Update from Divisions

Reducing Temporary and Agency Staff

One of our key areas of action in achieving greater financial stability is reducing the use of temporary and agency staff. Recent focus has improved the situation particularly in Brighton and Hove where a turnaround approach has been introduced and introducing similar principles in North West Sussex is also proving productive - other divisions are building on this learning. The work has involved a recruitment programme to fill vacant posts and increase the pool of available bank staff, but these are not the only areas being considered. There is a need to better understand the use of continuous observations and promote their therapeutic value not only in relation to reducing risk of self-harm and aggression but also in terms of preventing slips, trips and falls in our older people.

North West Sussex Action Plans

The plan to address issues at Langley Green Hospital is progressing well. Following the external review by Verita in December, it was agreed that the team focus on a smaller number of priorities. Most of these actions are now complete and are RAG rated green, however to be successfully embedded we need to monitor very rigorously. The areas include Safety: with particular focus on patient’s records and physical health care; Safeguarding: with regard to training and learning from safeguarding investigations; Environment: systems around ligature assessment, cleanliness and upkeep of the gardens; Leadership: establishing a leadership team and improving communication and Workforce. Of these priorities, workforce is perhaps one of the most challenging. Moving on the North West Sussex leadership team’s key focus is around patient and carer involvement.

We had a very productive meeting with Michael Wilson, CEO and his team Surrey and Sussex Healthcare NHS Trust looking at how we might best support each other in providing physical care and meeting the emotional needs of our patients. We have agreed to work together on sharing treatment protocols, for example: guidelines with LGH for physical health care, such as anticoagulant guidelines or insulin prescribing. Sharing teaching sessions e.g. mental health teaching for doctors based at ESH and physical health teaching for doctors at LGH. Visits have been arranged to help building relationships and we are planning a seminar with Surrey and Sussex police.
MANAGING DIRECTOR OF SPECIALIST SERVICES REPORT

SUMMARY & PURPOSE

This is my third update to the Council Governors as Interim Managing Director for Specialist Services. Over the last 3 months work has continued in all care groups developing and finalising their 3-5 year service plans. My report therefore provides more detail of these plans, the key headline objectives for each care group moving forward, the process that was followed to develop the plans and the benefits that have been achieved as a consequence, as well as some lessons learnt. In addition my report includes some of the key developments and issues underway within some of the care groups.

ACTION REQUIRED BY COUNCIL MEMBERS

Governors are invited to note the contents of the report and ask any questions and offer any suggestions for future themed reports.
1.0 Overview of Issues in Specialist Services

It has continued to be a busy time for each care group with the ongoing high level of demand on the services. In particular we continue to see high levels of people presenting in crisis who require immediate and often intensive support - this has been particularly noticeable in our Children and Young People’s services with demand for beds outstripping local and on occasion, national capacity.

Forensic Services
As of Wednesday 11th March, all secure and forensic services are smoke-free. In addition we also have a smoke-free inpatient service at HMP Lewes as of January 2015. This is work that has taken over a year to achieve and has been led brilliantly by Gary Davies-Ebsworth, Nurse Consultant.

HMP Lewes has now fully recruited to the new staff model, detailed implementation days have been held and services are in place for the delivery of the new model from April.

Complex Care Pathways
Peer to peer evaluation that is part of the Brighton and Hove Eating Disorder Service model has been successfully evaluated, presented to the CCG and funding is now agreed for a further year. In addition Coastal West Sussex CCG have provided some additional resource for the development of a similar model for that area.

Lindridge
The additional 26 beds (physical healthcare) have been block booked as part of the systems resilience project in Brighton and Hove. Further interest has been expressed by other areas about how additional nursing home bed capacity could support resilience across the system.

Hampshire CAMHS
Tender – The Intention To Tender (ITT) documentation has now been issued and work is underway to amend the documentation previously submitted to reflect any changes in the ITT and the increase in contract value. There are no changes to the service specification issued. The completed ITT will be submitted by 20th April 2015 with presentations for bidders shortlisted sometime in July 2015. The new contract commences April 2016.

Waiting list project progress – the service continues to deliver improvements in the work towards meeting waiting time targets with now 94% of young people being seen in less than 12 week... Although there is still a way to go there is month on month improvement.

Hampshire have also been consulting with the Quality Leads from the local CCGs regarding what they would like to see in the service Quality Account.
As a result of some of those suggestions the service now has a role in the
delivery of training to other agencies on suicide prevention and self-harm.
This will improve the quality of support across the whole system.

Kent Children and Young People Services
A project is now in place to cleanse the data and ensure the electronic data
reflects the progress that has been made in achieving waiting time targets. As
well as maintaining this progress, the service is focusing on developing
stronger external relationships with partners and stakeholders, particularly
parent and carer groups.

On Wednesday 11th March, Colm Donaghy took part in a live radio broadcast,
“in the hot seat” in Kent. Colm responded well to the questions raised and
was able to advise callers regarding the progress that Sussex Partnership had
made as well as developments and plans for further improvement. He was
also able to provide clarity on some of the pressures facing CAMHS services
nationally

2.0 Service Planning Process

Introduction
Specialist services have been following a process of service planning and
organisational development. The Board will recall that this was initially termed
as the Specialist Services Development Programme. The process was
designed to:

• Create a clear five year plan and service objectives for the year ahead
• Underpin robust financial and workforce plans
• Give greater ownership and responsibility on the part of leadership
teams
• Sustain changed relationship with corporate departments, readdressing
the balance which has been perceived at times to be unhelpfully
hierarchical and squeezed out responsibility and innovation at a service
level.

These actions would lead to improved staff morale and a better experience for
service users

The intention of the programme is to bring about cultural change across the
organisation, locating leadership and responsibility at the appropriate level.
Leadership Teams will be empowered to lead and, using enhanced
engagement and modelling of positive behaviours, staff and service users will
be equally empowered to influence service design and delivery.

One of the purposes of this report is to share identified learning across all
operational and corporate services. This links with the move towards ‘earned
autonomy’ and the process to establish ‘Care Delivery Units’. In addition the
paper seeks to share the key headline objectives for each care group going
forward.

Process followed
Sometimes it can feel that we are driven by events. There are so many
demands from regulators and commissioners that our organisation, like so
many NHS organisations can feel passive recipients rather than in control.
The fact that external demands are so high profile makes it difficult to drive
local initiatives as they have to compete for air time. It is therefore incredibly
important to follow principles of change management and create a sense of urgency and importance as well as putting in place robust processes. The key elements of the service planning process were:

- Executive commitment and sponsorship
- To agree and follow a plan with clear responsibilities
- Involvement from all corporate departments
- A service planning toolkit which set out a new framework for the plans
- Workshops to bring together leadership teams and corporate business partners to create a sense of team around the plans
- Clear deadlines requiring service directors to present their plans
- NED mentorship for each service

**Headlines from each care group**

Each care group plan is structured as:

- Vision for the future
- Analysis of current situation and the environment
- Analysis of the 6 Ps – Product, Place, Price, People, Promotion and Performance
- Financial plan
- Workforce plan
- Strategic priorities
- Business objectives
- Reporting and monitoring arrangements

Care groups varied the structure and combined subject headings in accordance with their needs to position their plans for effective communication. The key headlines from each plan are set out below.

**Secure and Forensic and Prison Healthcare**

Secure services are very well placed to grow as a national player and to have a growing role in the South East.

The service has identified eight strategic priorities which are:

- Preparing for forthcoming tenders
- Expansion of the existing sites
- Developing a secure Learning Disability service
- Embedding the local prison health pathway
- Achieving strong integration with adult mental health services
- Fully embedding the secure recovery service model
- Growing research and development
- Developing a bespoke vocational strategy

**Nursing Home**

The nursing home business is a new venture for the trust which has been established as a wholly owned subsidiary. It has undergone a period of rapid development and will take on the final phase of 26 beds in April 2015 which will mean the full complement of 76 beds are operational.

The service benefits from many of the freedoms derived from the commercial environment in which it operates. It perhaps can be more effective in moving quickly to respond to the needs of customers and business opportunities, and the priority is to ensure the commercial trajectory is achieved.
The service priorities are;

• Review the position of the model and decide the long term strategic development of the business.
• Build the occupancy levels in the Nursing Home plus service
• Introduce a new dementia service
• Investigate the clinical and business potential of a domiciliary care agency.

Learning Disabilities
Specialist learning disabilities services are well placed in the health system to make a major contribution to national strategy which is largely driven by the Winterbourne review. Our learning disabilities services are well placed to provide a system overview and help unblock the failures which have continued to see large numbers of people based unnecessarily in inpatient services. Locally there are good opportunities to ensure services are well integrated and for locally developed care pathways to be implemented and further improved.

The priorities for learning disabilities services are:

• To work with commissioners and other providers to implement new care pathways
• Ensure physical health is part of the pathway
• Develop community services particularly around crisis pathways
• The highest potential area for growth is intensively supported accommodation such as provided at Mayfield Court and would be in line with recommendations from the Winterbourne View and Bubb reports.
• Exploring the potential for additional inpatient assessment and treatment services
• A key strand of the strategy will be to ensure that people with learning disabilities have access to the same mental health support and mainstream services as the general population and are able to exercise their rights as an independent citizen.

Complex Care
Complex care services comprise 15 distinct clinical teams. They all operate as networks of services and offer integrated care pathways. The care group has been very successful in working with commissioners at an opportunistic and tactical level developing pathways that involve multiple providers and complex conditions and have a sound track record in developing and providing innovative new models of care. As a result the provision of these highly respected specialist services is patchy and inconsistent.

The trust as a whole has a lot to learn from the evidenced based forward thinking approach to integrated healthcare which includes physical healthcare services and are designed around the person and not the silos of provision.

The priorities include:
• Agree a strategy for complex care pathways
• Development and expansion programme to encompass health psychology, pain management services, MSK, eating disorders and personality disorders, neuro-psychiatry and neuro-psychology.
• Contribute to the health promotion and prevention agenda through a robust evidenced based approach, links with physical health care services and reputation with commissioners.

Substance misuse services
The agreed strategy is to withdraw from the provision of community substance misuse services and to work with adult services to focus on our inpatient and dual diagnosis services. A business case will be developed to set out the medium to long term plan for these remaining elements which are seen to have a strong long term potential.

Children and Young People’s services
The Children and Young People’s Division comprises Child and Adolescent Mental Health Services (CAMHS) in Hampshire, Sussex, Kent and Medway and Early Intervention in Psychosis Services across Sussex. Using the lessons we have learnt through our extended area of delivery and innovation we will further develop services into a cohesive whole whilst retaining local focus, local priorities and local delivery.

Recent national benchmarking and health select committee reports, along with the governments announced intentions around parity of esteem, and increased funding has the potential to provide further investment and development opportunities. A major strand may be through the delivery of integrated services.

Children and young peoples’ services have four strategic priorities:
• Pathways will be designed locally and fully embedded within integrated service provision where appropriate ie neurodevelopmental diagnosis and support
• Support the prevention and wellbeing agenda across the tiers in a variety of roles, ie direct provision, co-ordination, consultation ie supporting the Self-Harm agenda
• Working with partners, investigate the potential for services to be designed from 0-25 ie develop Youth Services from existing models to meet local need
• Develop transition pathways that reflect the unique needs of young people and their networks.
• Maximise opportunities for further growth of both community and inpatient services where these are viable and quality provision can be provided.

Learning
Overall the programme is widely regarded as a success because care group leadership teams now have clear strategic plans which enjoy wide support. At the same time, this improvement offers even greater possibilities and learning across the services and wider organisation.

What worked well:
• Leadership teams have gone through a development process and are in a stronger position to produce and deliver their strategic objectives through integrated plans
• Clinical leadership is refining its position and sphere of influence
• Staff engagement and critical reflection used to secure the development process
• Corporate business partners are more closely aligned and have a much deeper understanding of the service priorities
• There is a better process of developing longer term financial strategies
• There is a clearer sense of prioritisation
• Designing a performance and quality framework within a regulatory framework
• The service planning framework was one that practitioners could identify with
• It enabled specialist services to work together on elements in a more formal and documented way

Lessons learnt:
• The process takes longer than expected. Initial aims to write the plans in the workshops were not possible because it takes time to develop the teams involved. It will be quicker next time round.
• The toolkit used can be developed. The format of the final plans did not follow the toolkit but the toolkit helped take forward the thinking.
• It is very important to locate the primary ownership and responsibility for the plans with the relevant service / clinical directors and to use them for their personal objective setting as part of the appraisal process.
• The financial planning needs to go further incorporating CIP delivery projects rather than just setting the targets based on the expected variables

Conclusion and next steps
Overall the process of developing care group service plans has been very successful and really helped develop the leadership capability and capacity of teams within specialist services. This process is a good step towards the introduction of care delivery units because a prerequisite of their introduction is:
• a clear service plan
• a capable and empowered leadership team and
• business partnering arrangements in place from corporate departments

In addition the process has contributed to the development of the overall Trust plan and suggests that expecting all care groups to produce an annual service plan is a useful mechanism going forward, which can be used to set personal objectives of members of those leadership teams.

3.0 Recommendation/Action Required
Governors are invited to note the contents of the report and ask any questions and offer any suggestions for future themed reports.
FINANCE & PERFORMANCE REPORT

SUMMARY & PURPOSE

This report provides the Council of Governors with a summary of the Trust's financial performance and progress being made in delivering its regulatory and contractual performance indicators to the end of February, Month 11 of the financial year. The report details the main issues and the work that is being undertaken to ensure that the Trust delivers a breakeven position for 2014/15 and meets all its key performance indicators.

In February the Trust continued to report a monthly operating deficit of £700k. However, after the release of £300k of contingency reserves and taking account of an additional £250k from High Weald, Lewes and Havens CCG, the Trust is reporting a surplus for the month of £90k, reducing the year to date deficit to £1.9m. The year to date deficit means that the Trust continues to report a Continuity of Services Risk Rating of 3, against a planned rating of 4.

The Trust is now reliant on financial support from commissioners if it is to deliver a break even position for 2014/15. Discussions with commissioners are on-going and not yet concluded.

The Trust continues to make good progress on meetings it’s regulatory, contractual and other performance indicators.

LINK TO ANNUAL PLAN

The Annual Plan objective’s this paper relates to include:-

- Quality and Experience of patients
- Finance, information and performance
- People

ACTION REQUIRED BY COUNCIL OF GOVERNORS

The Council of Governors is asked to note and discuss the Finance and Performance Report.
1.0 Executive Summary

1.1 In February the Trust continued to report a monthly operating deficit of £700k. However, after the release of £300k of contingency reserves and taking account of an additional £250k from High Weald, Lewes and Havens CCG, the Trust is reporting a surplus for the month of £90k, reducing the year to date deficit to £1.9m. The year to date deficit means that the Trust continues to report a Continuity of Services Risk Rating of 3, against a planned rating of 4.

1.2 The Trust is now reliant on financial support from commissioners if it is to deliver a break even position for 2014/15. Discussions with commissioners are on-going and not yet concluded.

1.3 The Trust continues to make good progress on meetings it’s regulatory, contractual and other performance indicators.

1.4 The Council of Governors is asked to note and discuss the Finance and Performance Report

2.0 Introduction

2.1 This report provides the Council of Governors with a summary of the Trust’s financial performance and progress being made in delivering its regulatory and contractual performance indicators to the end of February, Month 11 of the financial year. The report details the main issues and the work that is being undertaken to ensure that the Trust delivers a breakeven position for 2014/15 and meets all its key performance indicators.

2.2 The Council of Governors is asked to note and discuss the Finance and Performance report.

3.0 Finance Report

3.1 Overview

In February the Trust continued to report a monthly operating deficit of £700k. However, after the release of £300k of contingency reserves and taking account of an additional £250k from High Weald, Lewes and Havens CCG, the Trust is reporting a surplus for the month of £90k, reducing the year to date deficit to £1.9m. The year to date deficit means that the Trust continues to report a Continuity of Services Risk Rating of 3, against a planned rating of 4.

The main area of concern is still the financial position of Adult Services, particular in relation to the use of private beds and overspends in the in-patient units. Significant work is therefore required to improve the position for Adult Services, as well as maintaining and in some cases improving the under-spending in both Specialist and Corporate services.

The areas of concern contributing to the financial position and the work being undertaken to address these issues is set out in the body of the report, together with the details of the overall financial position.

Details of income and expenditure and the financial risk rating for Month 11 are shown in the performance dashboard attached to this paper.
3.2 Income
In February income was £179k ahead of plan (Month 10: £215k, over plan), reducing the year to date under performance to £834k. In the month the Trust also secured an additional £250k from High Weald, Lewes and Havens CCG to fund cost pressures. Discussions are still progressing to secure additional income from other CCGs for 2014/15.
The year to date under performance on income is mainly due to the shortfall in cost per case income, which is currently £1,014k under plan, of which £909k relates to Lindridge, which is partly off-set by a corresponding reduction in the planned level of pay costs, due to the slippage on the new beds coming into operation. This position is now starting to improve due to the block contract with Brighton and Hove commissioners for 10 of the new beds for a 10 week period starting from the beginning of February to help address the bed pressures in acute services in Brighton.

3.3 Pay
Overall pay was overspent in the month by £388k (Month 10: £320k), taking the year to date overspend on pay to £2,518k. The main pressures are still in Adult Services, which was £582k overspent on its pay budgets in the month.

The overspend in Adult Services is mainly as a result of staffing levels on the adult acute and dementia in-patient services. Given that this will be a significant area of the cost improvement plan for Adult Services in 2015/16, specific work with ward managers and general managers is being undertaken by finance and HR to ensure that there is clarity about ward budgets and the expectation to operate within these budgets once they have been signed off by the Executive Director of Nursing & Quality. Discussions are also continuing to be held with commissioners as part of the contract negotiations for 2015/16 to secure additional funding to support safer staffing levels.

Expenditure on agency staff was £620k in February (Month 10: £617k). However, there was an improvement in the level of agency usage in Children and Young People’s Services, where spend reduced by £36k in the month. It should also be noted that there was no agency usage in the Prison Service this month. The use of agency in Adult Services remains high, totalling £342k in the month, with particularly concerns in North West Sussex, where agency usage increased in the month to £159k (Month 10: £136k), with the spend now accounting for 15% of their monthly pay bill.

The use of agency staff is one of the Trust’s highest risks and significant work is being undertaken to reduce the level of agency usage both from a financial and quality perspective.

3.4 Non-pay
In February non-pay expenditure was overspent by £331k (Month 10: £398k), of which £105k related to the cost of external placements, which was a reduction of £90k in the month. Other areas of overspend included drug costs (£110k) and slippage on the delivery of cost improvement plans (£65k).

There continues to be pressures on the use of beds in Adult Services, which is reflected in the continued use of external placements, which have cost the Trust £1.4m year to date. Business continuity plans are still in place with daily bed calls to try to manage patients within the Trust’s own bed base. Plans are currently being made for the Easter bank holiday at the beginning of April, where demand for services is expected to increase.

3.5 Operational Performance
In terms of operational performance, Operational Services were over spent by £432k in the month (Month 10: £781k), however this was after taking account of the £250k additional funding from High Weald, Lewes and Havens CCG to cover cost pressures in East Sussex. Before taking account of the additional funding, the overspend in Adult Services was £740k in the month (Month 10: £885k). There is now a significant challenge for Adult Services to reduce
this level of overspend and each division is working on detailed plans to forecast their position
for Month 1. Specialist services underspent by £57k in the month (Month 10: £104k), with good
performance across the services, with the exception of the nursing home which was overspent
by £45k (Month 10: £76k) due to the reasons set out earlier in the report.
Corporate Services were overspent by £113k in the month (Month 10: £121k), with the main
overspends being the £50k first instalment for the Listening into Acton initiative and the shortfall
in the cost improvement programme in Estates and Facilities.

3.6 Cost Improvement Plan (CIP)
Overall in the month £863k was saved against a target of £1,348k, which is a slight reduction
compared to the £926k that was saved in January. This increases the year to date savings to
£8,017k, which is £3,138k less than planned.

The main reasons for the year to date variance are the lack of progress in Adult Services in
tackling the on-going cost pressures related to ECR costs, ward overspends, and agency
expenditure, this accounts for £1,039k of the variance, there is a variance of £515k against the
Working Smarter project, which will not now not release savings until the second half of
2015/16.

Work is continuing in all of these areas to address the shortfalls. However, based on the
current forecast position, this year’s cost improvement plan is expected to deliver savings of
£9m, resulting in a gap of £3.5m. A further concern is that of the savings, £3.5m are non-
recurrent.

3.7 Forecast Out-turn and Financial Recovery Plan
At the end of February the Trust is reporting a deficit position of £1.9m. The Trust’s target is to
achieve a break even position by the end of the financial year, although it should be noted that
this is the best case position due to the continuing pressures on beds, use of agency staff, and
delivery of the cost improvement plan. The best case position is also reliant on the receipt of
additional income from commissioners which is currently being negotiated. The mid case
forecast is a deficit of £1.2m, with the worst case forecast being a deficit of £1.7m.

4.0 Performance Report

4.1 Trust Performance Dashboards

The Trust Performance dashboards attached to this paper present the Trust’s performance for
February. They are presented as follows:-

(a) A Trust wide performance dashboard covering Quality, Finance, and People
indicators that are appropriate to report for the Trust as a whole.

(b) An Adult Services performance dashboard covering the performance of the Adult
Services directorate.

(c) A Specialist Services performance dashboard covering the performance of the
Specialist Services Directorate. This includes Child and Adolescent Mental Health
Services, Secure & Forensic Services, Learning Disabilities, Substance Misuse
Services, Prison Services and Intermediate Care Services.

4.2 Monitor Indicators

The Trust has achieved the following indicators in February: 7 day follow-ups,
Early Intervention new cases of psychosis, Gate-keeping of Inpatient Admissions,
Access to Healthcare for people with a Learning Disability, Mental Health Minimum
Dataset (completeness) and Mental Health Minimum Dataset (Outcomes) and Patients
on CPA having had a Formal Review within the last 12 months achieved the target in
Over the last quarter the Trust has focused on delayed transfers of care. As people are admitted to our inpatient wards when their needs are at their most acute, ensuring they have a timely and well planned discharge is extremely important, to the individual and people who care about them, and also to the Trust’s capacity to help as many people as possible when they are most vulnerable. At the end of February the Trust is reporting a high level of delayed transfers of care, 9.1% compared to the 7.5% target set by Monitor. There is high number of delays due to a lack of suitable residential placements in Brighton, particularly for patients in the local Dementia ward. Housing issues are also impacting on patients in the Trust rehabilitation wards in West Sussex. The Trust is working closely with Social Care partners to address these issues.

### 4.3 Trust Wide Performance Dashboard

**Patient Experience: Friends & Family test:**
Patient experience is now being reported through the Friends and Family Test. This is a nationally mandated patient experience survey which the Trust has been required to implement in all services by 1st January 2015. It asks patients and their carers to rate whether they would recommend the service received to friends and family in similar circumstances. The survey asks for a rating on the scale from extremely likely to extremely unlikely and asks for a reason for the rating. Team leads and service managers will receive a summary of their feedback on a weekly basis. In February a positive response was received by 89% of respondents. 57% of respondents would be extremely likely to recommend the service to friends and family.

**Patient Experience, Complaints:**
This month reports a sustained improvement in agreed target response times. 85% of complaints were responded to within 25 days or the agreed timeframe. 62 new complaints were received in February. Complaints took an average of 23 days to resolve.

Continuous service improvements are in progress and the focus for this work is the quality of our responses alongside developing systems and processes that capture learning and triangulate with patient experience.

**People, Time to Hire:** The average time to hire in the Trust was 15.0 weeks in February against a previously agreed target of 17.4 weeks. The application of this performance indicator to different staff groups is being reviewed as part of the 2015/16 Trust objectives.

**People, Sickness Absence:** The sickness absence rate for January 2015 was 5.3%, which compares to 4.2% for the same month in the prior year. The main cause of sickness was “colds, coughs and flu”. Detailed action plans are reviewed routinely at all management meetings and individual case monitoring takes place between HR Business Managers and appropriate Operational Managers.

**People, Agency Spend:** Total agency spend in February is 4.0% of the total month’s pay bill compared to 4.1% in the previous month. All areas of agency spend are reviewed in detail at monthly performance. The majority of agency spends related to nursing. This is predominately used in inpatient wards across Brighton, Hastings, Langley Green and the Burrows as well as Kent Children and Young People’s service.

**Appraisals:** The target for the completion of appraisals by the end of Q3 is 95%. Monthly surveys of staff have run since June 2014. The year-to-date figure for the completion of appraisals, based on these surveys, is 90%. Teams are now required to
report on appraisals in the monthly performance meetings. Additionally, individual teams are being followed up to confirm completion of appraisals and for the reasons behind any non-completions.

**Data Quality:** The Trust has achieved the Monitor data quality indicators relating to the completeness of key fields and the completeness of information relating to key outcome measures. A data quality lead is in place as part of the Clinical Information Systems programme and is developing action plans for each area to improve data quality. The data quality dashboard has led improvements in data quality over the past few months, as set out in the table below.

<table>
<thead>
<tr>
<th>Item</th>
<th>Target</th>
<th>2nd July</th>
<th>11th March</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>98.5%</td>
<td>93.2%</td>
<td>99.8%</td>
</tr>
<tr>
<td>GP Practise</td>
<td>98.5%</td>
<td>95.5%</td>
<td>99.9%</td>
</tr>
<tr>
<td>Postcode</td>
<td>98.5%</td>
<td>98.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Inactive Referrals on systems</td>
<td>0</td>
<td>38.2%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Multiple referrals to the same team</td>
<td>0</td>
<td>282</td>
<td>128</td>
</tr>
</tbody>
</table>

**4.4 Specialist Services Performance Dashboard**

**Safety, Serious Incidents:** 5 Serious incidents (SIs) were reported in Specialist Services in February, 2 in Kent and 2 in Sussex and one in Hampshire. 2 grade 2 Serious Incidents (Grade 2 is the most serious category) in the month.

**Effectiveness, Urgent Referrals:** 100% of urgent referrals were seen within the required contractual timeframe in Sussex, Hampshire and Kent & Medway in February.

**Waiting times to assessment, Sussex:** 100% of urgent referrals were seen within the required contractual timeframe in Sussex, Hampshire and Kent & Medway in February.

**Waiting times to assessment, Hampshire:** Performance against waiting times in Hampshire Children and Young people’s services have improved slightly in the last month.

In month assessment appointments continue within 12 weeks of referral with 94% of referrals seen within 12 weeks, 70% being seen within 8 weeks and 46% in 4 weeks. The team in Hampshire have produced a trajectory for meeting the waiting times targets.

**Waiting times to assessment, Kent & Medway:** Performance against waiting times in Hampshire Children and Young people’s services have improved slightly in the last month.

In month assessment appointments continue within 12 weeks of referral with 94% of referrals seen within 12 weeks, 70% being seen within 8 weeks and 46% in 4 weeks. The team in Hampshire have produced a trajectory for meeting the waiting times targets.

**Average Length of stay:** The dashboard graph describes the average length of stay of patients on discharge from Chalkhill, the Trust CAMHS inpatient unit based on the Princess Royal Acute Hospital site in Haywards Heath. The average length of stay was 95 days on discharge in the last quarter ending December 2014 compared to 65 days in 2014-15 overall. The service expects that the average length of stay will vary on a month by month basis depending on the patient diagnosis. Patients with Eating Disorders, for example, generally have a longer stay.
Effectiveness Prison Transfer: Access to Mental Health Services for adult patients – transfer times from prison: Transfer times from prison to the mental health bed for individuals under section 7/48 of the Mental Health Act should be no more than 14 days from the date that the transfer warrant was issued by the Ministry of Justice (MOJ). 1 prisoner was transferred in February, within the required timeframe.

Patient Experience – Long Term Service Users, Sussex CAMHS: The Trust offers rapid re-assessments to patients who have received services from the Trust within the last two years. In February 95% of all patients referred for reassessment were assessed within the target of 7 days.

4.5 Adult Services Performance Dashboard

Safety, Serious Incidents: 10 Serious Incident (SI) were reported during February in Adult Services. There were no grade 2 (Grade 2 is the most serious category).

Effectiveness, Gatekeeping of Admissions: In February there were 201 admissions to Trust psychiatric acute inpatient services. 100% of these admissions were gate-kept by the Crisis & Home Treatment teams prior to admission. In gatekeeping patients, these teams look to provide home treatment whenever possible to avoid unnecessary acute admissions.

Effectiveness, 4 hour response to urgent referrals: 96.6% of urgent referrals meeting the required definition were responded to within 4 hours in February.

- There were 6 referrals that did not meet the target in Hastings & Rother. These are being investigated.

Effectiveness, 4 weeks waiting time to assessment: 96.9% of assessments were carried out occurred within 4 weeks of referral. Key actions agreed with commissioners include the following

- Supporting the triage function in the Brighton & Hove wellbeing service. A member of Trust staff has been co-located in the Brighton & Hove wellbeing service for a period of 3 months to support early identification of inappropriate referrals.
- Data quality and use of predictive system information to monitor potential waiting times breaches.
- Reviewing the alignment of GP clusters with named consultant psychiatrists to enhance relationships with primary care.
- Re-launching communication to GPs regarding the use of the 5 day priority gateway.

Effectiveness, Liaison services response rates: Sussex Partnership provides Mental Health Psychiatric Liaison services in Acute Hospitals across Sussex. The Trust plans to respond within 2 hours to emergency referrals, these could come from A&E wards, A&E linked wards or general wards. Urgent referral response times vary depending upon the ward, for A&E Linked this must be within 24 hours, and 48 hours for General Wards. All services were on target in February.

Effectiveness, Readmissions within 28 days: Sussex Partnership provides Mental Health Psychiatric Liaison services in Acute Hospitals across Sussex. The Trust plans to respond within 2 hours to emergency referrals, these could come from A&E wards, A&E linked wards or general wards. All services were on target in February.

Effectiveness, Length of stay: The average length of stay for adult 18-65 patients was 32 days, and for adults older than 65 it was 50 days in Q3 2014/15. An increased
length of stay is one of the key factors that impacts on the demand for psychiatric inpatient beds in Sussex. An acute dashboard is produced weekly for all wards that provide details of lengths of stays for patients’ admission, discharges and trends.

**Patient Experience, Delayed Transfers of Care:** The Trust is reporting 9.1% delayed transfers of care in February; against the Monitor target of 7.5%. 56 patients were delayed at the end of February.

There is high number of delays due to a lack of suitable residential placements in Brighton, particularly for patients in the local Dementia ward. Housing issues are impacting on patients in the Trust rehabilitation wards in West Sussex. The Trust is working closely with Social Care partners to address these issues.

**Rapid Reassessment of long term service users:** The Trust offers rapid reassessments to patients who have received services from the Trust within the last two years. 92% of the assessments carried out in February happened within 7 days. (There were 181 people who met the criteria in the month). A number of patients not seen in the timeframe in Brighton were seen later in accordance with their clinical needs.

**Payment By Results (PbR) Reassessments:** The Trust is preparing for the introduction of Payment by Results for Mental Health. The Trust is working towards an internal target of 95% of patients having their needs reassessed according to the cluster specific timeframes by the end of the financial year. At the end of February, 81% of adult patients had received a PbR reassessment within the required timeframe.

### 4.6 Governance Rating

The Trust governance rating, which is assessed quarterly, is green at the end of quarter 3, 2014/15.

### 4.0 Recommendation/Action Required

The Council of Governors is asked to:

- note and discuss the Finance and Performance Report

### 5.0 Next Steps

Progress on the delivery of the Trust’s financial position and performance in meetings it’s regulatory, contractual and other performance indicators will continued to be monitored through the Executive Assurance Committee, Finance and Investment Committee and Trust Board on a monthly basis.
Council of Governors’ Performance Report

February 2015
### SAFETY

<table>
<thead>
<tr>
<th>Serious Incidents - Reporting on and demonstrating learning</th>
<th>No Target</th>
</tr>
</thead>
</table>

### PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>Reporting patient experience feedback - Friends and Family Test</th>
<th>No Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints resolved within 25 working days - target 85%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
</tbody>
</table>

### PEOPLE

<table>
<thead>
<tr>
<th>Time to Hire - Trust-wide 15 weeks or less</th>
<th>TRUST-ONLY TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness absence - 3.5% or less</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Agency spend - maintain spend at less than 1% of pay bill</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Appraisals (85% by the end of Q1 and 100% by end of Q2)</td>
<td>TRUST-ONLY TARGET</td>
</tr>
</tbody>
</table>

### DATA QUALITY

<table>
<thead>
<tr>
<th>MHMDS Data Completeness Identifiers - target 97%</th>
<th>MONITOR TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMDS Data Completeness Outcomes - target 50%</td>
<td>MONITOR TARGET</td>
</tr>
</tbody>
</table>

### FINANCE

<table>
<thead>
<tr>
<th>Financial Risk Ratings (3 or above)</th>
<th>MONITOR TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of Cost Improvement Plan</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Income and Expenditure Account (£2.5m surplus by year end)</td>
<td>TRUST-ONLY TARGET</td>
</tr>
</tbody>
</table>

### RAG Status

- **Green (upward) arrow**: performance meets or exceeds target
- **Amber (horizontal) arrow**: performance less than 10% below target
- **Red (downward) arrow**: performance is 10% or more below target
### Serious Incidents

**TRUST-WIDE (Local indicator)**

Month: February 2015

<table>
<thead>
<tr>
<th>All Serious Incidents</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sussex (Adult &amp; Specialist)</td>
<td>12</td>
<td>142</td>
</tr>
<tr>
<td>Hampshire (Specialist)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kent (Specialist)</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Corporate</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TRUST</td>
<td>16</td>
<td>158</td>
</tr>
<tr>
<td>Grade 2 incidents only</td>
<td>2</td>
<td>18</td>
</tr>
</tbody>
</table>

### Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>Location</th>
<th>Adult</th>
<th>Specialist</th>
<th>Grade 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Crawley</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High Weald</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Patient Experience Feedback
Trust-wide (Local indicator)

Month: February 2015

Friends & Family Test
- Month: February 2015
- Quarter: 631
- YTD: 1307
- % Positive: 89.3%
- % Extremely Likely: 56.6%
- % Negative: 6.6%
- % Extremely Unlikely: 1.7%

% Extremely Likely: 56.6%
% Extremely Unlikely: 1.7%

Figures reported from September 2014 onwards

Resolving Complaints
(Local indicator)

Month: February 2015

Resolved within 25 working days or agreed timeframe
- Complaints resolved this month: 47
- Resolved within the agreed timeframe: 40
- % resolved within agreed timeframe: 85.1%
- Average number of days to resolution: 23.1

Number of complaints received: 62

Performance by CCG - February 2015

SUSSEX
- Coastal W Sussex: 10, 100.0% resolved, Ave Days: 16.8
- Crawley: 5, 40.0% resolved, Ave Days: 44.6
- Horsham & Mid Sx: 4, 100.0% resolved, Ave Days: 22.0
- Brighton & Hove: 10, 100.0% resolved, Ave Days: 20.5
- Eastbourne: 3, 66.7% resolved, Ave Days: 39.0
- High Weald: 2, 50.0% resolved, Ave Days: 19.5
- Hastings & Rother: 2, 100.0% resolved, Ave Days: 13.5
- S-E Hampshire: 0

HAMPSHIRE
- Fareham: 0
- N E Hampshire: 1, 100.0% resolved, Ave Days: 13.0
- West Hampshire: 2, 100.0% resolved, Ave Days: 33.0

Performance by CCG - February 2015

KENT
- Ashford: 1, 100.0% resolved, Ave Days: 21.0
- Canterbury: 0
- Dartford: 1, 0.0% resolved, Ave Days: 26.0
- Medway: 1, 100.0% resolved, Ave Days: 19.0
- South Kent Coast: 2, 100.0% resolved, Ave Days: 11.0
- Swale: 0
- Thanet: 0
- West Kent: 1, 100.0% resolved, Ave Days: 4.0
February 2015
Key Indicators - People

Sussex Partnership
NHS Foundation Trust

Time to Hire
TRUST-WIDE (Local indicator)

Month: February 2015  
Target: <=15 weeks  
Month 2014-5

- Time to Hire - TRUST (weeks) 15.0 15.2
- Time to Hire - Adult Services 11.1
- Time to Hire - Specialist Services 16.1

The average time to hire was 25.6 weeks in 2013. The 2014-5 figure is the average for the year-to-date since April 2014.

Sickness Absence
TRUST-WIDE (Local indicator)

Month: January 2015  
Target: <=3.5%  
Month Year

- 2014-15 absence rate 5.30% 4.05%
- 2013-14 absence rate 4.17% 4.14%

Reported one month in arrears. The 2013-14 year figure is for the whole 12 month period.

Agency Spend
TRUST-WIDE (Local indicator)

Month: February 2015  
Target: 1%  
Month YTD

- Agency Spend (2014-15) 4.03% 4.38%
- Agency Spend (2013-14) 5.09% 4.40%

Agency spend as a proportion of the total pay bill. Target is to maintain this below 1%.
Last year’s YTD figure is for the whole year (2013-14).

Appraisals
TRUST-WIDE (Local indicator)

Month: February 2015  
Target: 95% by end of Q2 100% by end of Q3

- Appraisals completed 90.0%
- Appraisals not yet booked to take place before end of Q4 0.0%
February 2015
Key Indicators - Data Quality

Sussex Partnership NHS Foundation Trust

Data Completeness Identifiers
TRUST-WIDE (MONITOR indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Yearly</th>
<th>Quarterly</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Code</td>
<td>99.5%</td>
<td>99.5%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Gender</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>GP Code</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.9%</td>
</tr>
<tr>
<td>NHS Number</td>
<td>99.8%</td>
<td>99.9%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Postcode</td>
<td>99.3%</td>
<td>99.3%</td>
<td>98.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>

Target: 97%

Data Completeness Outcomes
TRUST-WIDE (MONITOR indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>MHMDS Outcome</th>
<th>Yearly</th>
<th>Quarterly</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>86.5%</td>
<td>87.2%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Employment</td>
<td>86.5%</td>
<td>87.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>HoNOS</td>
<td>88.9%</td>
<td>88.6%</td>
<td>92.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>87.4%</td>
<td>87.7%</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

Target: 50%
February has resulted in a continuity of service risk rating of 3, due to the large year to date deficit, which is being countered by the strong liquidity position.

Cost Improvement Plans

The year to date savings amounted to £8,016k against a target of £11,156k.

Income and Expenditure Account

February has resulted in a surplus of £90k, against a £200k surplus target.

The main in month issues relate to the shortfall of cost improvement targets within pay and non-pay, ECR costs, overspending inpatient wards, and high agency usage.
### SAFETY

- **Serious Incidents - Reporting on and demonstrating learning**: No Target
  - **RAG Status**: Green (upward) arrow

- **7 Day Follow-up - Acute inpatient discharges followed up <7 Days - 95% threshold**: Monitor Target
  - **RAG Status**: Green (upward) arrow

### EFFECTIVENESS

- **Crisis team gate-keeping - Avoiding unnecessary admissions - 95% threshold**: Monitor Target
  - **RAG Status**: Green (upward) arrow

- **Emergency referrals responded to in 4 hours - target 95%**: Contractual Target
  - **RAG Status**: Green (upward) arrow

- **Routine assessments within 4 weeks of referral - target 95%**: Contractual Target
  - **RAG Status**: Green (upward) arrow

- **Liaison Services response times - target 95% (emergency & urgent referrals)**: Contractual Target
  - **RAG Status**: Green (upward) arrow

- **Readmissions within 28 days**: No Target
  - **RAG Status**: Green (upward) arrow

- **Length of Stay**: No Target
  - **RAG Status**: Green (upward) arrow

### PATIENT EXPERIENCE

- **Delayed Transfers of Care - Timely discharge of patients - less than 7.5%**: Monitor Target
  - **RAG Status**: Green (upward) arrow

- **Long term service users reassessed in 7 days - 95% threshold**: Contractual Target
  - **RAG Status**: Green (upward) arrow

- **Care Programme Approach reviews (at least every 12 months) - target 95%**: Monitor Target
  - **RAG Status**: Green (upward) arrow

- **PbR - Reassessment frequency in accordance with patient needs**: Trust-Only Target
  - **RAG Status**: Green (upward) arrow

- **Complaints resolved within 25 working days - target 85%**: Contractual Target
  - **RAG Status**: Green (upward) arrow

### PEOPLE

- **Time to Hire - Trust-wide 15 weeks or less**: Trust-Only Target
  - **RAG Status**: Green (upward) arrow

- **Sickness absence - 3.5% or less**: Trust-Only Target
  - **RAG Status**: Green (upward) arrow

- **Agency spend - maintain spend at less than 1% of pay bill**: Trust-Only Target
  - **RAG Status**: Green (upward) arrow

- **Appraisals (85% by the end of Q1 and 100% by end of Q2)**: Trust-Only Target
  - **RAG Status**: Green (upward) arrow

### ACTIVITY & DATA QUALITY

- **External Referrals**: No Target

- **MHMDS Data Completeness Identifiers - target 97%**: Monitor Target
  - **RAG Status**: Green (upward) arrow

- **MHMDS Data Completeness Outcomes - target 50%**: Monitor Target
  - **RAG Status**: Green (upward) arrow

### GOVERNANCE

- **MONITOR Governance Risk Rating**: Monitor Target

### RAG Status

- **Green (upward) arrow**: performance meets or exceeds target
- **Amber (horizontal) arrow**: performance less than 10% below target
- **Red (downward) arrow**: performance is 10% or more below target

Details of the individual target ranges for each indicator can be found on page 10.
Serious Incidents
Adult Services (Local indicator)
Month: February 2015

<table>
<thead>
<tr>
<th>All Serious Incidents</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services</td>
<td>10</td>
<td>104</td>
</tr>
<tr>
<td>Grade 2 incidents only</td>
<td>0</td>
<td>12</td>
</tr>
</tbody>
</table>

Performance by CCG - February 2015

| Coastal W Sussex      | 2     | 22  |
| Crawley               | 0     | 13  |
| Horsham & Mid Sx      | 1     | 16  |
| Brighton & Hove       | 3     | 22  |
| Eastbourne            | 1     | 7   |
| High Weald            | 0     | 8   |
| Hastings & Rother     | 2     | 15  |
| S-E Hampshire         | 1     | 1   |

7 Day Follow-up
Adult Services (MONITOR Indicator)
Month: February 2015
Target: 95%

<table>
<thead>
<tr>
<th>Discharged</th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>234</td>
<td>2015</td>
<td>FEB</td>
<td>24</td>
</tr>
<tr>
<td>475</td>
<td>2015</td>
<td>MAR</td>
<td>21</td>
</tr>
<tr>
<td>2,863</td>
<td>2015</td>
<td>APR</td>
<td>21</td>
</tr>
<tr>
<td>225</td>
<td>2015</td>
<td>MAY</td>
<td>21</td>
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<tr>
<td>457</td>
<td>2015</td>
<td>JUN</td>
<td>21</td>
</tr>
<tr>
<td>2,777</td>
<td>2015</td>
<td>JUL</td>
<td>21</td>
</tr>
</tbody>
</table>

% Followed-up: 96.2% 96.2% 97.0%

Performance by CCG - February 2015

| Coastal W Sussex      | 66    | 65  | 98.5% |
| Crawley               | 10    | 8   | 80.0% |
| Horsham & Mid Sx      | 19    | 19  | 100.0%|
| Brighton & Hove       | 51    | 50  | 98.0% |
| Eastbourne            | 32    | 31  | 96.9% |
| High Weald            | 19    | 18  | 94.7% |
| Hastings & Rother     | 35    | 33  | 94.3% |
| S-E Hampshire         | 0     | 0   | 0%   |
February 2015
Key Indicators - Effectiveness

Gate-keeping of Admissions
Adult Services (MONITOR Indicator)

Month: February 2015
Target: 95%

<table>
<thead>
<tr>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Admissions</td>
<td>201</td>
<td>389</td>
</tr>
<tr>
<td>No. Gate-kept</td>
<td>201</td>
<td>389</td>
</tr>
<tr>
<td>% Gate-kept</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

AMHS patients under 65

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>Admissions</th>
<th>Gate-kept</th>
<th>% gate-kept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>50</td>
<td>50</td>
<td>100.0%</td>
</tr>
<tr>
<td>Crawley</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>26</td>
<td>26</td>
<td>100.0%</td>
</tr>
<tr>
<td>High Weald</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

4 hour response to urgent referrals
Adult Services (Local indicator)

Month: February 2015
Target: 95%

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP referrals received</td>
<td>82</td>
</tr>
<tr>
<td>Referrals meeting definition</td>
<td>58</td>
</tr>
<tr>
<td>% response under 4 hours</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

Urgent GP referrals presenting an immediate risk either to the patient or others require an immediate response and meet the "4 hour response" definition.

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>GP Referrals</th>
<th>Definition</th>
<th>% &lt;4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>21</td>
<td>12</td>
<td>91.7%</td>
</tr>
<tr>
<td>Crawley</td>
<td>4</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>7</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>23</td>
<td>19</td>
<td>100.0%</td>
</tr>
<tr>
<td>High Weald</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>17</td>
<td>11</td>
<td>90.9%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Brighton & Hove CCG is covered by the BURS service
4 week waiting time to assessment
Adult Services (Local indicator)

Month: February 2015  Target: 95%

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-14</td>
<td>99.2%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>96.8%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>May-14</td>
<td>97.1%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>100.0%</td>
</tr>
<tr>
<td>Jul-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Aug-14</td>
<td>99.3%</td>
</tr>
<tr>
<td>Sep-14</td>
<td>79%</td>
</tr>
<tr>
<td>Oct-14</td>
<td>99.6%</td>
</tr>
<tr>
<td>Nov-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Dec-14</td>
<td>97.2%</td>
</tr>
<tr>
<td>Jan-15</td>
<td>99.6%</td>
</tr>
<tr>
<td>Feb-15</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

Number of Assessments 1,021 12,201
% assessments <4 Weeks 96.9% 96.5%
Average Wait Days 14.2 13.8

Indicator covers AMHS (inc Dementia)
Average Wait Days = average wait time from receipt of referral to assessment.

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>Assessments</th>
<th>&lt;4 weeks</th>
<th>Wait Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>365</td>
<td>98.1%</td>
</tr>
<tr>
<td>Crawley</td>
<td>79</td>
<td>96.2%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>141</td>
<td>99.3%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>132</td>
<td>91.7%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>95</td>
<td>96.8%</td>
</tr>
<tr>
<td>High Weald</td>
<td>109</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>97</td>
<td>92.8%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

Liaison Services response times
Adult Services (Local indicator)

Month: February 2015  Target: 95%

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-14</td>
<td>99.3%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>98.8%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>97.8%</td>
</tr>
<tr>
<td>May-14</td>
<td>96.1%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Jul-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Aug-14</td>
<td>91.7%</td>
</tr>
<tr>
<td>Sep-14</td>
<td>90.0%</td>
</tr>
<tr>
<td>Oct-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Nov-14</td>
<td>95.0%</td>
</tr>
<tr>
<td>Dec-14</td>
<td>97.7%</td>
</tr>
<tr>
<td>Jan-15</td>
<td>99.7%</td>
</tr>
<tr>
<td>Feb-15</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Emergency referrals 382 3,816
% responded to within target 96.3% 97.5%

Urgent referrals 240 2,573
% responded to within target 99.2% 99.7%

Performance by Locality - February 2015

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Sussex</td>
<td>118</td>
<td>57</td>
<td>96.0%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>178</td>
<td>70</td>
<td>96.4%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>86</td>
<td>113</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

West Sussex Acute Hospitals
- St Richards Hospital
- The Princess Royal Hospital
- Worthing District General Hospital

East Sussex Acute Hospitals
- Eastbourne District General Hospital
- The Conquest Hospital

Brighton Acute Hospital
- The Royal Sussex County Hospital
Readmissions within 28 days
Adult Services (local indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>Month</th>
<th>AMHS &lt;65 Patients Discharged</th>
<th>% AMHS &lt;65 Readmitted</th>
<th>AMHS 65+ Patients Discharged</th>
<th>% AMHS 65+ Readmitted</th>
<th>All AMHS Patients Discharged</th>
<th>% all AMHS Readmitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-14</td>
<td>232</td>
<td>16.8%</td>
<td>55</td>
<td>1.8%</td>
<td>287</td>
<td>13.9%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>2,561</td>
<td>14.1%</td>
<td>711</td>
<td>6.5%</td>
<td>3,272</td>
<td>12.4%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>2,871</td>
<td>14.6%</td>
<td>852</td>
<td>7.1%</td>
<td>3,723</td>
<td>12.4%</td>
</tr>
<tr>
<td>May-14</td>
<td>31.4</td>
<td>11.8%</td>
<td>12.3</td>
<td>0.0%</td>
<td>36.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>34.8</td>
<td>16.7%</td>
<td>12.5</td>
<td>6.3%</td>
<td>40.3</td>
<td>32.9</td>
</tr>
<tr>
<td>Jul-14</td>
<td>38.1</td>
<td>16.8%</td>
<td>31.4</td>
<td>15.0%</td>
<td>50.3</td>
<td>49.4</td>
</tr>
<tr>
<td>Aug-14</td>
<td>41.8</td>
<td>15.0%</td>
<td>43.7</td>
<td>11.6%</td>
<td>52.6</td>
<td>36.7</td>
</tr>
<tr>
<td>Sep-14</td>
<td>43.7</td>
<td>15.0%</td>
<td>48.4</td>
<td>13.9%</td>
<td>59.3</td>
<td>41.8</td>
</tr>
<tr>
<td>Oct-14</td>
<td>47.9</td>
<td>15.0%</td>
<td>43.7</td>
<td>11.6%</td>
<td>60.0</td>
<td>41.8</td>
</tr>
<tr>
<td>Nov-14</td>
<td>51.2</td>
<td>15.0%</td>
<td>50.3</td>
<td>13.9%</td>
<td>65.4</td>
<td>51.1</td>
</tr>
<tr>
<td>Dec-14</td>
<td>56.2</td>
<td>15.0%</td>
<td>58.5</td>
<td>12.8%</td>
<td>70.9</td>
<td>52.9</td>
</tr>
<tr>
<td>Jan-15</td>
<td>60.0</td>
<td>15.0%</td>
<td>58.8</td>
<td>12.8%</td>
<td>75.6</td>
<td>52.9</td>
</tr>
<tr>
<td>Feb-15</td>
<td>65.4</td>
<td>15.0%</td>
<td>60.0</td>
<td>11.1%</td>
<td>80.0</td>
<td>52.9</td>
</tr>
</tbody>
</table>

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>AMHS &lt;65</th>
<th>AMHS 65+</th>
<th>AMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>21.4%</td>
<td>0.0%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Crawley</td>
<td>11.1%</td>
<td>0.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>7.1%</td>
<td>0.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>17.3%</td>
<td>12.5%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>12.8%</td>
<td>0.0%</td>
<td>11.1%</td>
</tr>
<tr>
<td>High Weald</td>
<td>15.0%</td>
<td>0.0%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>26.7%</td>
<td>0.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Average Length of Stay
Adult Services (Local indicator)

Current Quarter: Quarter 3 (Oct - Dec)

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Quarter</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult - 18 - 65</td>
<td>28</td>
<td>31.4</td>
</tr>
<tr>
<td>Adult - 65+ Functional</td>
<td>50</td>
<td>50.3</td>
</tr>
<tr>
<td>Adult - Organic</td>
<td>60</td>
<td>85.7</td>
</tr>
</tbody>
</table>

Length of Stay is measured in days for patients discharged during last quarter.

Performance by CCG - Quarter 3 (Oct - Dec)

18-65 65+ Functional

<table>
<thead>
<tr>
<th>CCG</th>
<th>18-65</th>
<th>65+ Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>30.9</td>
<td>58.5</td>
</tr>
<tr>
<td>Crawley</td>
<td>38.1</td>
<td>87.0</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>36.7</td>
<td>50.3</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>31.1</td>
<td>43.7</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>30.2</td>
<td>34.8</td>
</tr>
<tr>
<td>High Weald</td>
<td>26.3</td>
<td>79.8</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>29.5</td>
<td>41.8</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>33.5</td>
<td></td>
</tr>
</tbody>
</table>
February 2015
Key Indicators - Patient Experience

Delayed Transfers of Care (DTC)
Adult Services (MONITOR Indicator)

Month: February 2015

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Delayed (Adult)</td>
<td>10.0%</td>
<td>7.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>% Delayed (TRUST)</td>
<td>9.1%</td>
<td>6.8%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Non-acute adult patients aged 18 and over from AMHS (inc Dementia). Reported to MONITOR quarterly. TRUST figure (for MONITOR) includes numbers from LDS and S&F.

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>Referrals</th>
<th>&lt;7 days</th>
<th>&lt;7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>75</td>
<td>75</td>
<td>100.0%</td>
</tr>
<tr>
<td>Crawley</td>
<td>21</td>
<td>19</td>
<td>90.5%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>20</td>
<td>17</td>
<td>85.0%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>23</td>
<td>15</td>
<td>65.2%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
</tr>
<tr>
<td>High Weald, Lewes</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>15</td>
<td>14</td>
<td>93.3%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patients referred back to AMHS within 2 years of their last episode (at least 6 months or more). Some referrals may be downgraded if clinically appropriate.
### February 2015

#### Key Indicators - Patient Experience

**CPA 12 month Formal Review**
Adult Services (MONITOR indicator)

Current Quarter: Quarter 3 (Oct - Dec)  
Target: 95%

<table>
<thead>
<tr>
<th>Month</th>
<th>Adults on CPA at end of quarter</th>
<th>Last Review within 12 months</th>
<th>% adults with review &lt;12 months</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>2,642</td>
<td>2,745</td>
<td>95.6%</td>
<td>95.0%</td>
</tr>
<tr>
<td>May-14</td>
<td>1,443</td>
<td>1,449</td>
<td>83.9%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Jun-14</td>
<td>83.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul-14</td>
<td>94.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug-14</td>
<td>95.0%</td>
<td>84.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep-14</td>
<td>80.2%</td>
<td>89.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct-14</td>
<td>97.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov-14</td>
<td>83.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-14</td>
<td>2,745</td>
<td>1,739</td>
<td>83.3%</td>
<td>98.1%</td>
</tr>
</tbody>
</table>

This MONITOR indicator is currently reported quarterly. A manual audit is completed at the end of the quarter.

---

**Performance by CCG - Quarter 3 (Oct - Dec)**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Patients</th>
<th>Valid Review</th>
<th>% Valid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>840</td>
<td>824</td>
<td>98.1%</td>
</tr>
<tr>
<td>Crawley</td>
<td>131</td>
<td>114</td>
<td>87.0%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>313</td>
<td>303</td>
<td>96.8%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>681</td>
<td>612</td>
<td>89.9%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>309</td>
<td>307</td>
<td>99.4%</td>
</tr>
<tr>
<td>High Weald</td>
<td>116</td>
<td>116</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>225</td>
<td>224</td>
<td>99.6%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>10</td>
<td>8</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

---

**Payment by Results (PbR)**
Adult Services (Local indicator)

Month: February 2015  
Target: 95%

<table>
<thead>
<tr>
<th>Category</th>
<th>Patients + valid Cluster</th>
<th>% valid Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>8,032</td>
<td>83.4%</td>
</tr>
<tr>
<td>Crawley</td>
<td>1,808</td>
<td>79.8%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>3,262</td>
<td>81.9%</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>3,045</td>
<td>72.3%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>2,519</td>
<td>83.2%</td>
</tr>
<tr>
<td>High Weald</td>
<td>1,739</td>
<td>83.3%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>2,253</td>
<td>83.8%</td>
</tr>
</tbody>
</table>

---

**Performance by CCG - February 2015**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Patients + valid Cluster</th>
<th>% valid Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>8,032</td>
<td>83.4%</td>
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<td>Crawley</td>
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<td>83.3%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>2,253</td>
<td>83.8%</td>
</tr>
</tbody>
</table>
### Resolving Complaints
**Adult Services (Local indicator)**

- **Month:** February 2015  
  - **Target:** 85%
- **Resolved within 25 working days or agreed timeframe:** 31
- **Resolved within the agreed timeframe:** 26
- **% resolved within agreed timeframe:** 83.9%
- **Average number of days to resolution:** 24.9
- **Total number of complaints received:** 42

### Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>Complaints</th>
<th>Resolved</th>
<th>Ave Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>9</td>
<td>100.0%</td>
<td>16.9</td>
</tr>
<tr>
<td>Crawley</td>
<td>5</td>
<td>40.0%</td>
<td>44.6</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>3</td>
<td>100.0%</td>
<td>21.0</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>7</td>
<td>100.0%</td>
<td>21.7</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>3</td>
<td>66.7%</td>
<td>39.0</td>
</tr>
<tr>
<td>High Weald</td>
<td>2</td>
<td>50.0%</td>
<td>19.5</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>2</td>
<td>100.0%</td>
<td>13.5</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Note:** The data includes various performance indicators for different CCGs, with percentages and average days to resolution. The chart illustrates the percentage of complaints responded to within the agreed timeframes for each CCG.
February 2015
Key Indicators - People
Sussex Partnership NHS Foundation Trust

Time to Hire
Adult Services (Local indicator)

Month: February 2015  Target: <=15 weeks
Month  2014-5
Time to Hire - TRUST (weeks)  15.0  15.2
Time to Hire - Adult Services  11.1

The average time to hire was 25.6 weeks in 2013. The 2014-5 figure is the average for the year-to-date since April 2014.

Sickness Absence
Adult Services (Local indicator)

Month: January 2015  Target: <=3.5%
Month  Year
Trust absence rate  5.30%  4.05%
Adult Services absence rate  6.24%  4.20%

Reported one month in arrears

Agency Spend
Adult Services (Local indicator)

Month: February 2015  Target: 1%
Month  YTD
Agency Spend (2014-15)  4.83%  4.80%
Agency Spend (2013-14)  5.21%  4.25%

Agency spend as a proportion of the total pay bill. Target is to maintain this below 1%. Last year’s YTD figure is for the whole year (2013-14).

Appraisals
TRUST-WIDE (Local indicator)

Month: February 2015  Target: 95% by end of Q2
100% by end of Q3

Appraisals completed 90.0%

Appraisals not yet booked to take place before end of Q4 0.0%
February 2015
Key Indicators - Activity & Data Quality

Sussex Partnership NHS Foundation Trust

External Referrals
Adult Services (Local indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>Location</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brighton &amp; Hove Locality</td>
<td>3,607</td>
<td>42,044</td>
</tr>
<tr>
<td>East Sussex Locality</td>
<td>771</td>
<td>8,647</td>
</tr>
<tr>
<td>West Sussex Locality</td>
<td>1,041</td>
<td>11,906</td>
</tr>
<tr>
<td>AMHS only</td>
<td>1,683</td>
<td>20,197</td>
</tr>
</tbody>
</table>

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>Location</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>1,042</td>
<td>12,857</td>
</tr>
<tr>
<td>Crawley</td>
<td>237</td>
<td>2,673</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>404</td>
<td>4,667</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>771</td>
<td>8,647</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>425</td>
<td>4,941</td>
</tr>
<tr>
<td>High Weald</td>
<td>239</td>
<td>2,700</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>377</td>
<td>4,265</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>6</td>
<td>85</td>
</tr>
</tbody>
</table>

Data Completeness Identifiers
TRUST-WIDE (MONITOR indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>MHMDS Identifier</th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Code</td>
<td>99.5%</td>
<td>99.5%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Gender</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>GP Code</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.9%</td>
</tr>
<tr>
<td>NHS Number</td>
<td>99.8%</td>
<td>99.9%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Postcode</td>
<td>99.3%</td>
<td>99.3%</td>
<td>98.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>

Data Completeness Outcomes
TRUST-WIDE (MONITOR indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>MHMDS Outcome</th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>86.5%</td>
<td>87.2%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Employment</td>
<td>86.5%</td>
<td>87.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>HoNOS</td>
<td>88.9%</td>
<td>88.6%</td>
<td>92.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>87.4%</td>
<td>87.7%</td>
<td>89.6%</td>
</tr>
</tbody>
</table>
7 Day Follow-up (page 1)

Patients are at their most vulnerable and most at risk of suicide within the first seven days after being discharged from an inpatient unit. The 7 day follow-up process attempts to reduce the number of suicides and serious incidents within this time frame.

Every adult patient, including those on the Care Programme Approach (CPA) receiving secondary mental health services should be followed up, either in person, or by phone, within 7 days of discharge.

The MONITOR and Contractual target is 95%. A schedule of working principles has been agreed to define expected practice.

RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Gate-keeping of Admissions (page 2)

A key role of the Crisis Resolution Home Treatment Team is to gate-keep admissions to inpatient services to reduce inappropriate inpatient admission and provide crisis care in the home or in the community where this is more appropriate.

They should provide a mobile 24 hour, seven days a week response to requests for assessment and be actively involved in all requests for admission. For the avoidance of doubt, this should involve face-to-face contact unless it can be deemed that this was not appropriate, or possible. For each case where face-to-face is deemed to be inappropriate, a self-declaration is required. In relation to Mental Health Act assessments the team should be notified of assessment; be assessing all these cases before admission happens; and be central to the decision making process in conjunction with the rest of the multi-disciplinary team.

The MONITOR and Contractual target is 95%. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

4 hour response to urgent GP referrals (page 2)

All Urgent GP referrals are carefully screened by clinicians, to ensure they are responded to in the most appropriate way. Where, in the view of the clinician, the patient is presenting an immediate risk to themselves or others; an immediate response is required. The response that the Trust makes must be adequate to address the level of risk described above. This could be either assessment, or other actions, to ensure the safety of the patient and others appropriate to the particular circumstances.

This indicator addresses the patient pathway from referral (from external source) to first assessment. It describes the numbers of external referrals achieving the 4 hour target across the Trust.

The indicator is expressed as the number of patients waiting less than 4 weeks between referral and first assessment. It takes the first contact following referral to represent assessment.

The Contractual target is that at least 95% wait under 4 weeks to first assessment following referral. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Urgent GP referrals for adult patients in Brighton & Hove are managed by the Enhanced Brighton Urgent Response Service.

4 weeks waiting time to assessment (page 3)

This indicator addresses the patient pathway from referral (from external source) to first assessment. It describes the numbers of external referrals achieving the 4 week target across the Trust.

The indicator is expressed as the number of patients waiting less than 4 weeks between referral and first assessment. It takes the first contact following referral to represent assessment.

The Contractual target is that at least 95% wait under 4 weeks to first assessment following referral. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Liaison Services response times (page 3)

Psychiatric liaison services provide mental health care to people being treated for physical health conditions in general acute hospitals. The co-occurrence of physical and mental health problems is very common and often leads to poorer health outcomes for these patients. It also has a detrimental effect on health care costs. The Centre for Mental Health issued a report in 2011 (Economic Evaluation of a Liaison Psychiatry Service) which estimated that an acute hospital could save £3.5m a year in shorter lengths of stay and lower readmission rates through the use of high-quality psychiatric liaison services. This represented a cost-benefit ratio of 4:1.

The targets for patients to be seen are:

- 2 hours for emergency referrals (A&E wards, A&E linked wards, general wards)
- 24 hours for urgent referrals (A&E linked wards)
- 48 hours for urgent referrals (general wards)
- For non-urgent referrals (general wards) the aspirational target is 72 hours

95% of patients should wait no more than indicated. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Delayed Transfers of Care (DTC) (page 5)

A delayed discharge occurs when a patient is assessed as medically ready to be discharged from an inpatient bed but remains due to non medical delays. These include, awaiting public funding, awaiting a housing placement or a package of care in their own home. A patient is ready for transfer when:

- A clinical decision has been made that patient is ready for transfer and
- A multi-disciplinary team decision has been made that patient is ready for transfer and
- The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting. For patients of no fixed abode, the council responsible for the patient is the council whose area they reside. This is irrespective of whether the patient lives on the street or in a hostel. Asylum seekers and others from overseas are listed under the council in which they currently reside. It is the responsibility of the local authority to decide whether they are eligible for social services.

The MONITOR and Contractual target is that DTCs should be no more than 7.5% (expressed as the number of bed days delayed divided by the total number of occupied bed days). RAG status: Green - 7.5% and below; Amber - 7.5-12.5%; Red - above 12.5%.

February 2015 10 Adult Services
Long Term Service Users (LTSU) (page 5)
People discharged to primary care after a long period of being supported by secondary services, May feel insecure about what will happen if their mental health should deteriorate. A rapid re-assessment will increase their confidence to live more independently.
95% of patients meeting the criteria below should be offered an assessment within 1 week.
- Patients in receipt of services for six months or more in their last episode.
- Patients were discharged no more than two years before the referral.
The Contractual threshold is 95%. The Trust’s aim is a target of 100%. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

CPA 12 month Formal Review (page 6)
"The Care Programme Approach (CPA) is at the centre of the personalisation focus, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what are often complex systems of care." - from the Foreword to 'Refocusing the Care Programme Approach—Policy and Positive Practice Guidance' Dept of Health (2008).
In identifying what a service user, who has the support of a CPA, should expect, the need for a comprehensive formal written care plan features prominently. This care plan should include a risk and safety/contingency/crisis aspect. An on-going, formal multi-disciplinary, multi-agency review is required at least once a year (but likely to be needed more regularly).
The 12 month review is a key MONITOR performance indicator. It is expressed as a percentage of adult patients having had a formal review in the past 12 months from the total number of adults on the Care Programme Approach at any time in the past 12 months.
The MONITOR target is that 95% of all patients on CPA should have had at least one formal review in the past 12 months. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Payment by Results (PbR) cluster reassessment (page 6)
Under the Department of Health Guidance for Payment By Results, there is a requirement that patients, whose needs are defined in terms of Payment By Results clusters, are re-assessed in accordance with defined review periods. The defined review periods vary in length according to the cluster concerned. Clusters are considered as "valid" if the patients' needs have been re-assessed in the review period and the patient has been re-clustered.
There are a number of possible reasons as to why a patient may have an EXPIRED cluster including:
- Patients with no current activity that have not been discharged from the system. (these patients need to be discharged).
- Patients whose clusters have not been reviewed within the defined review periods. (all patients need to be clustered in accordance with the review periods guidance).
RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Responding to Complaints (page 7)
All complaints are taken extremely seriously. They must be fully investigated with care and consideration and the findings reported to the complainant.
There is a clear correlation between satisfaction and responsiveness and the Trust has taken the decision that complaints must be responded to within 25 working days, or within a different agreed timeframe.
The target is 85% of all complaints are responded to within 25 working days or different agreed timeframe. RAG status: Green - 85% and above; Amber - 75-85%; Red - below 75%.

MHMDS Data Completeness Identifiers and Outcomes (page 9)
The Mental Health Minimum Data Set (MHMDS) is a nationally defined framework of data held locally by Trusts around the country. Each record in the data set looks at the whole period an individual is cared for by the provider from the initial referral to the final discharge. The MHMDS is central in providing information for clinical audit and for the assessment of patient outcomes. At a local level the MHMDS data completeness enables monitoring of outcomes for individuals in terms of morbidity, quality of life and user satisfaction with services. The latest version (4.1) of MHMDS is used.
The indicator measures the completeness of the mental health minimum data set in two parts:
1. **Identifier - 6 selected data items**
   - Date of birth
   - Patient's current gender
   - Patient's NHS number
   - Postcode of patient's normal residence
   - Organisational code of patient's registered General Medical Practice
   - Organisational code of Commissioner

   The MONITOR target for is set at 97% overall. RAG status: Green - 97% and above; Amber - 95-97%; Red - below 95%.
2. **Outcomes - 3 selected data fields**
   (using the most recent entered for adult patients aged 18-69 on CPA in the last 12 months)
   - Settled accommodation
   - Employment
   - HoNOS

   The MONITOR target for is set at 50% overall. RAG status: Green - 50% and above; Amber - 45-50%; Red - below 45%.
<table>
<thead>
<tr>
<th>SAFETY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Incidents - Reporting on and demonstrating learning</td>
<td>No Target</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EFFECTIVENESS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency referrals responded to in 4 hours (Sussex) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Emergency referrals responded to in 4 hours (CAMHS Hants) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Emergency referrals responded to in 24 hours (ChYPS Kent) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>New cases of psychosis - Effective treatment - 48 new cases each quarter</td>
<td>MONITOR TARGET</td>
</tr>
<tr>
<td>Routine assessments within 4 weeks of referral (Sussex) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Routine assessments within 4 weeks of referral (CAMHS Hants) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Routine assessments within 4 weeks of referral (ChYPS Kent) - target 95%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Length of Stay (CAMHS Sussex)</td>
<td>No Target</td>
</tr>
<tr>
<td>Appropriate Placement of Prisoners - prisoner transfer times - target &lt;2 weeks</td>
<td>TRUST-ONLY TARGET</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT EXPERIENCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term service users reassessed in 7 days (CAMHS Sussex) 95% target</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Complaints resolved within 25 working days (Sussex) - target 85%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Complaints resolved within 25 working days (CAMHS Hants) - target 85%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
<tr>
<td>Complaints resolved within 25 working days (ChYPS Kent) - target 85%</td>
<td>CONTRACTUAL TARGET</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEOPLE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Hire - Trust-wide 15 weeks or less</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Sickness absence - 3.5% or less</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Agency spend - maintain spend at less than 1% of pay bill</td>
<td>TRUST-ONLY TARGET</td>
</tr>
<tr>
<td>Appraisals (85% by the end of Q1 and 100% by end of Q2)</td>
<td>TRUST-ONLY TARGET</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITY &amp; DATA QUALITY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>External Referrals (CAMHS Sussex)</td>
<td>No Target</td>
</tr>
<tr>
<td>MHMDS Data Completeness Identifiers - target 97%</td>
<td>MONITOR TARGET</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOVERNANCE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MONITOR Governance Risk Rating</td>
<td>MONITOR TARGET</td>
</tr>
</tbody>
</table>

**RAG Status**

- Green (upward) arrow: performance meets or exceeds target
- Amber (horizontal) arrow: performance less than 10% below target
- Red (downward) arrow: performance is 10% or more below target

Details of the individual target ranges for each indicator can be found on page 10
February 2015
Key Indicators - Safety

Sussex Partnership
NHS Foundation Trust

Serious Incidents
Specialist Services (Local indicator)

Month: February 2015

All Serious Incidents Month YTD
Specialist Services 5 52
Sussex 2 38
Hampshire 1 1
Kent 2 13

Grade 2 incidents only 2 6

Performance by CCG - February 2015

Month YTD
Coastal W Sussex 0 4
Crawley 0 0
Horsham & Mid Sx 0 8
Brighton & Hove 1 6
Eastbourne 0 10
High Weald 1 7
Hastings & Rother 0 3
S-E Hampshire 0 0
**February 2015**  
**Key Indicators - Effectiveness**

### 4 hour response to urgent referrals  
**Specialist Services - CAMHS Sussex (Local Ind)**

- **Month:** February 2015  
- **Target:** 95%

<table>
<thead>
<tr>
<th>Category</th>
<th>Referrals</th>
<th>Meeting Definition</th>
<th>% Response under 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP referrals received</td>
<td>52</td>
<td>448</td>
<td>100.0%</td>
</tr>
<tr>
<td>Referrals meeting definition</td>
<td>9</td>
<td>123</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Urgent GP referrals presenting an immediate risk either to the patient or others require an immediate response and meet the "4 hour response" definition.

### Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>Referrals</th>
<th>Definition</th>
<th>% Response &lt;4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>20</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Crawley</td>
<td>4</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>8</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Brighton</td>
<td>12</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>3</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>High Weald</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>5</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### 4 hour response to urgent referrals  
**Specialist Services - CAMHS Hants (Local Ind)**

- **Month:** February 2015  
- **Target:** 95%

<table>
<thead>
<tr>
<th>Category</th>
<th>Referrals</th>
<th>Meeting Definition</th>
<th>% Response under 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP referrals received</td>
<td>47</td>
<td>520</td>
<td>100.0%</td>
</tr>
<tr>
<td>Referrals meeting definition</td>
<td>12</td>
<td>107</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Urgent GP referrals presenting an immediate risk either to the patient or others require an immediate response and meet the "4 hour response" definition. CAMHS Hampshire.

### Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>CCG</th>
<th>Referrals</th>
<th>Definition</th>
<th>% Response &lt;4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fareham</td>
<td>10</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>North Hampshire</td>
<td>20</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>N E Hampshire</td>
<td>0</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>S E Hampshire</td>
<td>3</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>West Hampshire</td>
<td>14</td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
February 2015
Key Indicators - Effectiveness

Sussex Partnership
NHS Foundation Trust

24 hour urgent referrals
Specialist Services - ChYPS Kent (Local Ind)

Month: February 2015
Target: 95%

Emergency referrals received
103
Emergency referrals seen
103
% seen under 24 hours
100.0%

Emergency referrals presenting an immediate risk either to the patient or others must be seen within 24 hours, irrespective of whether within normal or out-of-hours.

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>Referrals</th>
<th>Definition</th>
<th>% &lt;24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Canterbury</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
</tr>
<tr>
<td>Dartford</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medway</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
</tr>
<tr>
<td>South Kent Coast</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Swale</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Thanet</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>West Kent</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

EIS - New Psychosis Cases
Specialist Services (MONITOR indicator)

Month: February 2015

National Target: 48 cases/quarter

<table>
<thead>
<tr>
<th>Region</th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Sussex</td>
<td>3</td>
<td>4</td>
<td>74</td>
</tr>
<tr>
<td>East Sussex</td>
<td>6</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>7</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>TRUST</td>
<td>18</td>
<td>27</td>
<td>183</td>
</tr>
</tbody>
</table>

Reported to MONITOR quarterly.
February 2015
Key Indicators - Effectiveness

Specialist Services - CAMHS Sussex (Local Ind)

<table>
<thead>
<tr>
<th>Month: February 2015</th>
<th>Target: 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Assessments</td>
<td>468</td>
</tr>
<tr>
<td>% assessments &lt;4 Weeks</td>
<td>98.9%</td>
</tr>
<tr>
<td>Average Wait Days</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Indicator covers CAMHS Sussex and LDS.
Average Wait Days = average wait time from receipt of referral to assessment.

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>SUSSEX</th>
<th>Assessments</th>
<th>&lt;4 weeks</th>
<th>Wait Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>108</td>
<td>97.2%</td>
<td>12.9</td>
</tr>
<tr>
<td>Crawley</td>
<td>29</td>
<td>93.1%</td>
<td>16.3</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>55</td>
<td>100.0%</td>
<td>12.4</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>58</td>
<td>100.0%</td>
<td>16.8</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>60</td>
<td>100.0%</td>
<td>13.6</td>
</tr>
<tr>
<td>High Weald</td>
<td>49</td>
<td>100.0%</td>
<td>12.7</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>107</td>
<td>100.0%</td>
<td>10.3</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td>0%</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Specialist Services - CAMHS Hants (Local Ind)

<table>
<thead>
<tr>
<th>HAMPSHIRE</th>
<th>Assessments</th>
<th>&lt;4 weeks</th>
<th>Wait Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fareham</td>
<td>45</td>
<td>17.8%</td>
<td>45.2</td>
</tr>
<tr>
<td>North Hampshire</td>
<td>34</td>
<td>55.9%</td>
<td>33.9</td>
</tr>
<tr>
<td>N E Hampshire</td>
<td>31</td>
<td>38.7%</td>
<td>55.7</td>
</tr>
<tr>
<td>S E Hampshire</td>
<td>49</td>
<td>44.9%</td>
<td>37.9</td>
</tr>
<tr>
<td>West Hampshire</td>
<td>107</td>
<td>52.3%</td>
<td>38.2</td>
</tr>
</tbody>
</table>

4 week waiting time to assessment

February 2015 Target: 95%
Month YTD
Number of Assessments 276 2,651
% assessments <4 Weeks 45.7% 44.1%
Average Wait Days 39.5 41.6

Indicator covers CAMHS Hampshire
Average Wait Days = average wait time from receipt of referral to assessment.
February 2015
Key Indicators - Effectiveness

4 week waiting time to assessment
Specialist Services - ChYPS Kent (Local Indicator)

Month: February 2015  Target: 95%

Number of Assessments 491  4,769
% assessments <4 Weeks 58.5% 47.9%
Average Wait Days 30.7  54.6

Indicator covers ChYPS Kent
Average Wait Days = average wait time from receipt of referral to assessment.

Performance by CCG - February 2015

![Bar chart showing performance by CCGs]

<table>
<thead>
<tr>
<th>CCG</th>
<th>Assessments</th>
<th>&lt;4 weeks</th>
<th>Wait Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>36</td>
<td>63.9%</td>
<td>30.0</td>
</tr>
<tr>
<td>Canterbury</td>
<td>60</td>
<td>63.3%</td>
<td>21.1</td>
</tr>
<tr>
<td>Dartford</td>
<td>60</td>
<td>63.3%</td>
<td>26.0</td>
</tr>
<tr>
<td>Medway</td>
<td>77</td>
<td>66.2%</td>
<td>28.7</td>
</tr>
<tr>
<td>South Kent Coast</td>
<td>53</td>
<td>49.1%</td>
<td>39.5</td>
</tr>
<tr>
<td>Swale</td>
<td>36</td>
<td>55.6%</td>
<td>30.7</td>
</tr>
<tr>
<td>Thanet</td>
<td>55</td>
<td>56.4%</td>
<td>38.8</td>
</tr>
<tr>
<td>West Kent</td>
<td>109</td>
<td>51.4%</td>
<td>32.0</td>
</tr>
</tbody>
</table>

Average Length of Stay
Specialist Services - CAMHS Sussex (Local ind)

Current Quarter: Quarter 3 (Oct - Dec)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>CAMHS</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 - 2013-14</td>
<td>94.4</td>
<td>65.1</td>
</tr>
</tbody>
</table>

Length of Stay is measured in days for patients discharged during last quarter.

Appropriate Placement for Prisoners
Specialist Services - S&F (Local indicator)

Month: February 2015  Target: 100%

Under 2 weeks 1  16
TOTAL 1  16

Prisoner transfer time from receipt of Ministry of Justice warrant to hospital bed. Target is under 2 weeks.
February 2015
Key Indicators - Patient Experience

Sussex Partnership NHS Foundation Trust

Long Term Service Users Referrals
Specialist Services (Local indicator)

Month: February 2015
Target: 95%

LTSU Referrals
37
391

Seen within 7 days
35
381

% seen within 7 days
94.6%
97.4%

Patients referred back to CAMHS within 2 years of their last episode (which must have lasted at least 6 months).

Performance by CCG - February 2015

Coastal W Sussex 5 4 80.0%
Crawley 1 0 0.0%
Horsham & Mid Sx 4 4 100.0%
Brighton & Hove 6 6 100.0%
Eastbourne 7 7 100.0%
High Weald, Lewes 8 8 100.0%
Hastings & Rother 6 6 100.0%
S-E Hampshire 0
February 2015
Key Indicators - Patient Experience

Sussex Partnership
NHS Foundation Trust

Resolving Complaints
Specialist Services (Local indicator)

Month: February 2015  Target: 85%
Resolved within 25 working days or agreed timeframe
Complaints resolved this month 15
Resolved within the agreed timeframe 13
% resolved within agreed timeframe 86.7%
Average number of days to resolution 19.5

Total number of complaints received 19

Performance by CCG - February 2015

SUSSEX

<table>
<thead>
<tr>
<th>CCG</th>
<th>Complaints</th>
<th>Resolved</th>
<th>Ave Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>1</td>
<td>100.0%</td>
<td>16.0</td>
</tr>
<tr>
<td>Crawley</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>1</td>
<td>100.0%</td>
<td>25.0</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>2</td>
<td>100.0%</td>
<td>15.5</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Weald</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance by CCG - February 2015

HAMPSHIRE

<table>
<thead>
<tr>
<th>CCG</th>
<th>Complaints</th>
<th>Resolved</th>
<th>Ave Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fareham</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Hampshire</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N E Hampshire</td>
<td>1</td>
<td>100.0%</td>
<td>13.0</td>
</tr>
<tr>
<td>S E Hampshire</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Hampshire</td>
<td>2</td>
<td>100.0%</td>
<td>33.0</td>
</tr>
</tbody>
</table>

Performance by CCG - February 2015

KENT

<table>
<thead>
<tr>
<th>CCG</th>
<th>Complaints</th>
<th>Resolved</th>
<th>Ave Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td>1</td>
<td>100.0%</td>
<td>21.0</td>
</tr>
<tr>
<td>Canterbury</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dartford</td>
<td>1</td>
<td>0.0%</td>
<td>26.0</td>
</tr>
<tr>
<td>Medway</td>
<td>1</td>
<td>100.0%</td>
<td>19.0</td>
</tr>
<tr>
<td>South Kent Coast</td>
<td>2</td>
<td>100.0%</td>
<td>11.0</td>
</tr>
<tr>
<td>Swale</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thanet</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Kent</td>
<td>1</td>
<td>100.0%</td>
<td>4.0</td>
</tr>
</tbody>
</table>
February 2015
Key Indicators - People

Sussex Partnership NHS Foundation Trust

Time to Hire
Specialist Services (Local indicator)
Month: February 2015  
Target: <=15 weeks
Month  2014  
Time to Hire - TRUST (weeks)  
15.0  
15.2
Time to Hire - Specialist Services  
16.1

The average time to hire was 25.6 weeks in 2013. The 2014-5 figure is the average for the year-to-date since April 2014.

Sickness Absence
Specialist Services (Local indicator)
Month: January 2015  
Target: <=3.5%
Month  Year  
Trust absence rate  
5.30%  
4.05%
Specialist Services absence rate  
5.57%  
4.06%

Reported one month in arrears

Agency Spend
Specialist Services (Local indicator)
Month: February 2015  
Target: 1%
Month  YTD  
Agency Spend (2014-15)  
4.95%  
5.24%
Agency Spend (2013-14)  
6.58%  
5.70%

Agency spend as a proportion of the total pay bill. Target is to maintain this below 1%. Last year’s YTD figure is for the whole year (2013-14).

Appraisals
TRUST-WIDE (Local indicator)
Month: February 2015  
Target: 95% by end of Q2  
100% by end of Q3

Appraisals completed  
90.0%

Appraisals not yet booked to take place before end of Q4  
0.0%
February 2015
Key Indicators - Activity & Data Quality
Sussex Partnership
NHS Foundation Trust

External Referrals
Specialist Services - CAMHS & EIS Sussex

Month: February 2015

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of External Referrals</td>
<td>946</td>
</tr>
<tr>
<td>Brighton &amp; Hove Locality</td>
<td>176</td>
</tr>
<tr>
<td>East Sussex Locality</td>
<td>342</td>
</tr>
<tr>
<td>West Sussex Locality</td>
<td>396</td>
</tr>
</tbody>
</table>

CAMHS Sussex & EIS only

Performance by CCG - February 2015

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal W Sussex</td>
<td>231</td>
</tr>
<tr>
<td>Crawley</td>
<td>50</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sx</td>
<td>115</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>176</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>105</td>
</tr>
<tr>
<td>High Weald</td>
<td>105</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>132</td>
</tr>
<tr>
<td>S-E Hampshire</td>
<td>0</td>
</tr>
</tbody>
</table>

Data Completeness Identifiers
TRUST-WIDE (MONITOR indicator)

Month: February 2015

<table>
<thead>
<tr>
<th>MHMDS Identifier</th>
<th>Month</th>
<th>Quarter</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Code</td>
<td>99.5%</td>
<td>99.5%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Gender</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>GP Code</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.9%</td>
</tr>
<tr>
<td>NHS Number</td>
<td>99.8%</td>
<td>99.9%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Postcode</td>
<td>99.3%</td>
<td>99.3%</td>
<td>98.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.5%</td>
</tr>
</tbody>
</table>
Performance Indicators 2014 - 2015
Sussex Partnership
NHS Foundation Trust

4 hour response to urgent GP referrals (pages 2)
All urgent GP referrals are carefully screened by clinicians, to ensure they are responded to in the most appropriate way. Where, in the view of the clinician, the patient is presenting an immediate risk to themselves or others; an immediate response is required. The response that the Trust makes must be adequate to address the level of risk described above. This could be either assessment, or other actions, to ensure the safety of the patient and others appropriate to the particular circumstances. This may not necessarily mean meeting the patient face-to-face. This could be achieved through discussion with the GP or patient. The clinical responsibility is to ensure that the GP’s request has been responded to and the patient is safe.

100% of all urgent GP referrals that meet the definition must be responded to within 4 hours. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Early Intervention Services - New Psychosis Cases (page 3)
Early intervention services work with young people aged between 14 and 35. Patients referred to the Service are usually either at risk or are experiencing a first episode of psychosis. Research has shown that the longer an episode of psychosis goes untreated, the poorer the outlook. Research has also indicated that early intervention services may reduce hospital stays, reduce relapses and lower suicide rates.

MONITOR requires that the agreed Commissioner contract figures for new cases, either those on extended assessment or those added to the three-year caseload, are met on a quarterly basis. The Contractual target is 48 new cases per quarter. RAG status: Green - on or above target; Amber - within two cases of target; Red - more than two cases off target.

4 weeks waiting time to assessment (pages 4 & 5)
This indicator addresses the patient pathway from referral (from external source) to first assessment. It describes the numbers of external referrals achieving the 4 week target across the Trust.

The indicator is expressed as the number of patients waiting less than 4 weeks between referral and first assessment. It takes the first contact following referral to represent assessment.

The Contractual target is that at least 95% wait under 4 weeks to first assessment following referral. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Long Term Service Users (LTSU) (page 6)
People discharged to primary care after a long period of being supported by secondary services, may feel insecure about what will happen if their mental health should deteriorate. A rapid re-assessment will increase their confidence to live more independently.

95% of patients meeting the criteria below should be offered an assessment within 1 week.
- Patients in receipt of services for six months or more in their last episode.
- Patients were discharged no more than two years before the referral.

The Contractual threshold is 95%. The Trust’s aim is a target of 100%. RAG status: Green - 95% and above; Amber - 85-95%; Red - below 85%.

Responding to Complaints (page 7)
All complaints are taken extremely seriously. They must be fully investigated with care and consideration and the findings reported to the complainant.

There is a clear correlation between satisfaction and responsiveness and the Trust has taken the decision that complaints must be responded to within 25 working days, or within a different agreed timeframe.

The target is 85% of all complaints are responded to within 25 working days or different agreed timeframe. RAG status: Green - 85% and above; Amber - 75-85%; Red - below 75%.

MHMDS Data Completeness Identifiers and Outcomes (page 9)
The Mental Health Minimum Data Set (MHMDS) is a nationally defined framework of data held locally by Trusts around the country. Each record in the data set looks at the whole period an individual is cared for by the provider from the initial referral to the final discharge. The MHMDS is central in providing information for clinical audit and for the assessment of patient outcomes. At a local level the MHMDS data completeness enables monitoring of outcomes for individuals in terms of morbidity, quality of life and user satisfaction with services. The latest version (4.1) of MHMDS is used.

- Identifier - 6 selected data items
  - Date of birth
  - Patient’s current gender
  - Patient’s NHS number
  - Postcode of patient’s normal residence
  - Organisational code of patient’s registered General Medical Practice
  - Organisational code of Commissioner

The MONITOR target for is set at 97% overall. RAG status: Green - 97% and above; Amber - 95-97%; Red - below 95%.
<table>
<thead>
<tr>
<th>CCG</th>
<th>Population (2013-14)</th>
<th>Number of GP Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coastal West Sussex CCG</td>
<td>492,515</td>
<td>55</td>
</tr>
<tr>
<td>Crawley CCG</td>
<td>127,372</td>
<td>13</td>
</tr>
<tr>
<td>Horsham &amp; Mid Sussex CCG</td>
<td>228,231</td>
<td>23</td>
</tr>
<tr>
<td>Brighton &amp; Hove CCG</td>
<td>300,900</td>
<td>46</td>
</tr>
<tr>
<td>Eastbourne, Hailsham &amp; Seaford CCG</td>
<td>186,798</td>
<td>22</td>
</tr>
<tr>
<td>High Weald, Lewes, Havens CCG</td>
<td>166,464</td>
<td>27</td>
</tr>
<tr>
<td>Hastings &amp; Rother CCG</td>
<td>183,178</td>
<td>33</td>
</tr>
<tr>
<td>South Eastern Hampshire CCG</td>
<td>209,845</td>
<td>26</td>
</tr>
</tbody>
</table>
# PATIENT EXPERIENCE REPORT

## SUMMARY & PURPOSE
The paper provides a quarterly update report on progress across patient experience programmes.

## SPECIFIC POINTS FOR GOVERNORS TO NOTE
The Friends and Family Test (FFT) is now implemented across the Trust and the focus is now upon maximising its potential as a service improvement tool.

The 15 Steps Challenge is now in its third phase and has recently visited four Assessment and Treatment Services (ATS) where it has proved useful in identifying strengths and areas for improvement.

Patient experience reporting has an opportunity to develop significantly in depth and richness as a consequence of the greater levels of qualitative feedback gained via the FFT. The first quarterly Patient Experience Report will be presented to the Quality Committee in May 2015.

There are several patient experience initiatives taking place across the Trust which, if successful, may be developed and employed elsewhere to support greater service user engagement and service improvement.

## ACTION REQUIRED BY COUNCIL MEMBERS
Council of Governors are invited to note the contents of this report for information and discussion.
1.0 Introduction

Friends and Family Test

The FFT was launched in all acute hospital inpatient and accident and emergency departments in April 2013, and maternity services in October 2013. The standard question in these settings being asked is “How likely are you to recommend our <ward> to friends and family if they needed similar care or treatment?” The survey also invites the respondent to rate the service on a scale of very unlikely to extremely likely and to give a reason for their rating in a free text box.

From January 2015 the FFT has become a mandatory requirement for mental health trusts to carry out. Following a phased roll out the FFT across the later part of 2014, the survey has been successfully applied across all our services – Adult, Dementia and Later Life, Children and Young people, Substance Misuse, Secure and Forensic, Learning Disability and all other specialist services.

Implementation and development across the Trust

Whilst the programme lead is still supporting a small number of teams to embed FFT within their practice, the focus is now moving from implementation, to how we can best employ FFT as a service improvement tool. We have configured our approach so that individual teams are aware of and have responsibility for responding to the feedback that they receive. To support this intention, a team level report has been developed which contains the free text comments received in relation to the specific service, which can then be displayed directly on ‘You said - We did’ boards. This report is sent directly to the nominated manager for the team to action.

To date, we are receiving predominantly positive feedback and as of March 23rd March, we have received 855 responses in 2015: 761 of these were ‘extremely likely or likely’ to recommend the service, whereas only 38 were ‘extremely unlikely or unlikely’ to. Amongst this feedback, individual members of staff are regularly singled out for praise and we are actively encouraging managers to ensure their staff receive this feedback.

Whilst the positive feedback is good news, we will be closely examining the suggestions for improvement given in the free text responses and seeing how services have responded to these. We will also be looking at ways to encourage respondents to give critical feedback so that we can improve our service delivery accordingly. Please see attachment for the latest FFT report that went to the Trust Board in March 2015.

15 Steps

The 15 Steps Challenge is a tool designed by the NHS Institute for Innovation and Improvement to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. It focuses on identifying what helps make service users and carers feel welcome and safe on their arrival at a Trust site. A ‘challenge team’, consisting of a service user or carer, a staff member and a trust governor or board member, walk onto the ward and take note of their first impressions using the toolkit to help structure their observations.
After the team has assessed the environment, they meet with the manager in charge to give them first hand feedback regarding what is good and what might be improved.

Implementation and development across the Trust

In phase 1 of its implementation (2013), the 15 Steps Challenge visited all inpatient sites and in phase 2 2013-2014 33 return visits took place (7 less than the original cohort due to refurbishment and closure). Only 2 out of the 33 wards had made no improvement. Of the remaining wards, all had taken significant steps to address the areas for improvement that had been identified, though for some the problems remain outside the control of the service e.g. poor quality built environment and reception areas which are not managed by the Sussex Partnership. A small proportion (3) had new problems identified over and above those that had been raised and addressed previously.

Given the success of the initial work in inpatient settings, it was agreed that for phase 3 of its implementation, the challenge would focus upon Assessment and Treatment Services (ATS). Four visits to ATS sites (East Brighton Mental Health Centre, Hove Polyclinic, New Park House and Chapel street Clinic) have taken place so far in 2015 and they have been conducted using the ‘Clinic & Outpatient Settings Toolkit’ as this focuses more specifically on waiting areas and interactions between reception staff and service users, which previous visits have revealed to be a significant factor in the overall experience. These first visits also emphasised the need to include building managers in the process. This is primarily because the environments are often shared and they are the best placed person to answer queries about these spaces and share any concerns raised following the 15 Steps visits with relevant personnel.

The feedback from this latest phase of visits was overwhelmingly positive, with the team reporting clean, well-managed and friendly environments. In terms of improvement opportunities, these visits showed that in order for reception areas to be welcoming places more effort is needed in terms of ambience, seating arrangements, interactions between reception staff and service users and up-to-date signposting information.

It should also be noted that staff have been very welcoming towards the challenge, to the point where team leads not scheduled to have a visit have been contacting the team to request that they be included.

The following proposals for the first part of 2015 have been agreed by the Better by Experience Steering group:

- Rather than conducting any further standalone visits to inpatient units, we will work with Estates and Facilities Department to see whether the 15 Steps criteria can be included within their statutory annual ‘PLACE’ visits. (‘Patient-led Assessments of the Care Environment’ focus more closely on standards of cleanliness etc. but share much of the same intentions as the 15 Steps Visits)
- Work with services to consider the involvement of newer members of staff in the challenge
- Look to include the buildings manager as part of the team wherever possible
- Focus on ATS’s for the first 6 months of 2015 and report back to the Better by Experience Steering Group on its progress

Patient Experience Reporting and Initiatives:

Reporting

Whilst the free text responses that the FFT captures present a new level of Trust wide ‘qualitative’ feedback, it also presents a real challenge in terms of analysis. In
response to this, the Board has agreed that there should be a quarterly report that goes to the Quality Committee that is dedicated to patient experience which seeks to share this feedback and to triangulate it with other metrics (i.e. complaints). In addition, this report will provide updates on established patient experience initiatives, such as 15 Steps visits and on new projects. The first of these reports will be shared at the Quality Committee on May 7th and will then go to the Trust Board.

Initiatives

There is, of course, much work happening across the Trust that has improving patient experience at its heart. The following two examples serve to give a flavour of some of the work that is currently taking place:

‘Experience Based Co-Design’ (EBCD) on Pavilion Ward

EBCD comes from the King’s Fund and has been applied in many acute settings nationally, but we believe only twice before in a Mental Health Trust. Put simply, the approach is as follows:

- Create a 20-30 minute film of ex-service user talking about their experiences of care
- Play the finished film separately to the staff team, current/ex-service users and their carers and then play it to the group as a whole
- Have a facilitated discussion about the film and agree any areas that need to be reviewed as a consequence
- Set up a working group, comprised of members of each of the groups, to work together to make changes where needed

A steering group comprised of staff, ex-service user, Governor and film maker have been working to the above process and filming has started in March 2015. In addition to ex-service users, we are also looking to film carers and believe we are the first Mental Health Trust to do so. We believe this will provide a unique perspective and learning opportunity for all involved. It is intended that the finished film will be able to be used in other settings across the Trust, as an aide to promoting ‘co-production’ and to ensure we always ‘see the person in the patient’.

‘Inspire’ Questionnaire Trial

In 2014, members of the CCG for Coastal West Sussex raised their concern that, with the exception of medics, most clinicians did not get to receive direct feedback from service users regarding their practice. Acknowledging this to be the case, we agreed to look at existing tools/processes that are used nationally and to consider running a trial to see whether or not this approach was worthwhile for both clinicians and service users. Of the numerous tools available the ‘brief inspire’ questionnaire (http://www.researchintorecovery.com/INSPIRE) matches well the recovery principles we were trying to evaluate and was agreed to be used as the basis for the trial. The 5 questions are as follows:

1 My worker helps me to feel supported by other people
2 My worker helps me to have hopes and dreams for the future
3 My worker helps me to feel good about myself
4 My worker helps me to do things that mean something to me
5 My worker helps me to feel in control of my life
The service user is asked to rate these statements from ‘not at all’ to ‘very much’ and in addition we are including a separate box where they can add further comments.

After liaising further with Adult Services in Coastal West Sussex, the Assertive Outreach Team based in Bognor volunteered to trial this approach and the team are now looking to conduct the survey in the coming months. As well as individual clinicians receiving feedback, the feedback will be scored and themed and the team will be presented with the overall findings and consideration will be given to having a session with service users and their carers to discuss its findings. Learning from the project will be shared initially with the Better by Experience Steering group, where the adoption of this approach elsewhere in the Trust will be considered.

**2.0 Report**

1: **National Reporting Requirements from NHS England:**

Report due to be published on 27th March 2015.

2: **Overview of rating responses:**

The following graphs are broken down into groups that we feel ‘make sense’ to us as a Trust:

**Graphs 1 & 2: Responses by Division and CCG:**
## Responses by Division

**Base size:** 270

<table>
<thead>
<tr>
<th>Category</th>
<th>Brighton and Hove</th>
<th>CHYPS/CAMHS</th>
<th>Coastal West Sussex</th>
<th>Complex Care</th>
<th>East Sussex</th>
<th>Learning Disability</th>
<th>North West Sussex</th>
<th>Primary Care</th>
<th>Secure and Forensic</th>
<th>Substance Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely likely</td>
<td>11</td>
<td>42</td>
<td>22</td>
<td>12</td>
<td>22</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Likely</td>
<td>5</td>
<td>27</td>
<td>11</td>
<td>3</td>
<td>14</td>
<td>5</td>
<td>2</td>
<td>20</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Neither likely nor unlikely</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely</td>
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<tr>
<td>Extremely unlikely</td>
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<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3: Overview of free text responses:

Of the 270 responses for January only 6 people gave a satisfaction response of ‘extremely unlikely’. Of this very small sample size, no one theme emerged, but a couple of examples are cited below:

‘Extremely Unlikely:

Support my family so they can help me too-my mum is the only one who is really bothered about me, but she is tired and doesn't get help

Answered the phones?! Returned our calls? Stop cancelling appointments? Provide consistent therapy instead of repeat prescriptions and hoping for the best.

Nothing wrong with the staff just not enough involvement

‘Extremely Likely’

As in previous months, the number of extremely likely responses is very striking, with 149 people giving this rating. Reading through these responses, you cannot fail to be struck by the constant reference to individuals and teams and how grateful these respondents are for their support. It is therefore vital that this feedback is getting back to all of those named. Below are examples that give a flavour of this feedback

My reason is the consistent, magnificent service & help I have [been] given over the past 3 or so years. I would not have got through without.

The session I go to is immensely helpful to me (AIM relaxation class) as it appears to be also for the others in the group. The chap who runs the group is truly excellent and genuinely cares about people. It's about 50 minutes-once a week-and I go as often as I can.

The assessment, diagnosis, guidance and help I received was, as a service, way over and above what I was expecting - and the person providing it adapted it specifically to my circumstances, having understood exactly what I was saying. I guess I'm saying that I can't imagine it could be any better!

Finally, in response to the question that asks if we “could have done anything better”? there are numerous helpful suggestions that included:

Don't lose time for bureaucracy... People are here for us, not for computers and reports

Faster entry into system. Earlier intervention might have prevented things getting as bad as they did
As described in the introduction, this report is intended to provide a snapshot of the feedback we are receiving, whilst the fuller quarterly report will give much greater consideration for emergent themes, triangulation with other metrics and will highlight patient experience initiatives across the Trust.

That said, the data identified here has some interesting points to note, including:

- Overall the vast majority of people are rating our services positively
- The number of respondents decreased from our high of 389 in January and we will be continuing to work with teams to ensure we sustain momentum
- The free text comments are producing extremely rich feedback that often singles out individuals for praise and some helpful suggestions for improvement
- Given this richness of data, it is imperative that local managers are supported and encouraged to respond, so that staff are praised and actions are taken to improve services.
- It is also important that they are supported and encouraged to publicise their responses to this feedback via mechanisms such as ‘You Said- We Did’ Boards.

### 4.0 Next Steps

Monthly and Quarterly reports shall be produced from herein incorporating the recommendations from the Board.

For the remainder of this final quarter we will focus on:

- Continued encouragement for local teams/managers to take ownership of the responses relating to their service.
- Considering the first national publication of the FFT. This will enable us to review learning from other areas and use this to inform quality improvement work across our services.
- Development of a quarterly 'Patient Experience Report' which will look to capture themes and enable greater triangulation
- Develop this monthly report so that each month it has feedback related to a specific care group.
AUDIT OF LETTERS TO GPs

<table>
<thead>
<tr>
<th>SUMMARY &amp; PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortly prior to the Council of Governors meeting in January, some members highlighted the issue of clinic letters to GPs not consistently being copied to service users. This has been an issue the Council has raised a number of times before.</td>
</tr>
<tr>
<td>In response, an audit was carried out (Appendix 1) and this confirmed that the majority of service users do not receive copies of clinic letters.</td>
</tr>
<tr>
<td>At the Council meeting in April Dr Ojo will give a verbal update on the corrective action being taken to address this.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION REQUIRED BY COUNCIL OF GOVERNORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council members are asked to consider the findings of the Audit and, following the verbal update by Dr Tim Ojo, ask any questions arising from it.</td>
</tr>
</tbody>
</table>
Audit of clinic letters copied to patients

REPORT
January 2014-15

Author: Wendy Harlow, Clinical Audit Team Leader
1. Executive Summary

Background
The Department of Health (2003) and Royal College of Psychiatrists (2010) both publish good practice guidance on copying letters to patients. These include recommendations about when to copy correspondence (CC), and situations where not sharing is appropriate in mental health settings.

Service users at Sussex Partnership NHS Foundation Trust have recently raised concerns that letters are not regularly copied to them as often as they would like and have requested that this is explored further.

Aims and Objectives

The aim of the audit is to identify how many letters, sent to the patients General Practitioner after attendance at a clinic, are also copied to the service user.

The objectives are:
• To audit 2 letters each of all Community Psychiatrists
• To interview the Admin Team Leads of all eight Assessment & Treatment Services
• To survey all Community Psychiatrists
• Report to the Counsel of Governors
• Identify further actions to take forward as a result of the findings

Key results
• 90 (70%) of recent clinic letters sent to the GP had not been copied to the service user.
• 3 letters had been copied to the carer/person accompanying the service user to the appointment. 63 service users were accompanied to their clinic appointment by a carer, advocate or significant other person.
• Two clinic review letters had been addressed to the service user and the GP copied in.

115 service users had received other correspondence from the ATS or had been copied in to letters during the previous six months.

Conclusion

It is clear from the psychiatrist survey and the Admin Team Leader interviews that people believe letters are copied to service users in compliance with national recommendations. In the majority of cases Admin Team Leaders and Psychiatrists believe that there is a rigorous opt in/out process, albeit one which varies by psychiatrist and or location. In some cases this is communicated verbally and in others, service users are provided with an information sheet and consent form at initial assessment. However, the audit of letters shows that this is not the case and that the majority of service users do not receive copies of the clinic letters. It is beyond the remit of this audit to identify those cases where it would be inappropriate for people to receive this information as indicated in the DoH best practice guidance, however, it was noted that people do receive clinical information from other healthcare professionals and in many cases they receive some GP letters but not others.

It is clear that the onus is on the psychiatrist to reiterate on every dictation/letter that the service user has opted in/out from the admin support teams perspective. From the psychiatrist’s perspective, it appears they are under the impression that admin support will be responsible for ensuring this is done every time.

There are some excellent examples of where a service user has opted in to receive letters and subsequently have consistently been copied in to all correspondence. These examples have been led by psychiatrists who have had clear discussions with both the service user and their admin support team. The process is clear to all.

The conclusion from this is that people who would like to be copied in to their letters and where there is no clear rationale as to why they shouldn’t be will sometimes receive letters and sometimes they won’t. Two factors influence this. Firstly, if a service user has opted in it is not always clearly communicated between members of the healthcare and admin teams. Secondly, other than verbally, there is no capacity to store this information on electronic systems or set up reminders and in many cases staff will rely on memory.

It is beyond the remit of this audit to consider in detail, differences occurring geographically. However, it is noted that, difference in practice do occur geographically.
SECTION 1

1.1 Background Information
The Department of Health (2003) and Royal College of Psychiatrists (2010) both publish good practice guidance on copying letters to patients. These include recommendations about when to copy correspondence (CC), and situations where not sharing is appropriate in mental health settings.

‘In some cases involving particularly sensitive areas, however, such as child protection or mental health problems, it may not be appropriate to copy a letter to the patient, although the patient has the right to request access under the Data Protection Act 1998. Unless the health professional’s judgement is that there might be a serious possibility of harm to the patient, it is up to the patient to decide whether they wish to receive a copy of a letter.’ See Section 4: Consent to receipt of letters; identifying appropriate recipients. (DoH 2003)

‘Provided that the patient agrees, letters from one psychiatrist to another, or to another health professional, should be copied to the patient to improve the patient’s understanding of their mental health and the care they are receiving.’ (RCPsych 2010)

Good practice guidelines on copying clinic letters to patients have also been published by the Royal College of Psychiatrists for Old Age Psychiatrists (2004). Since the NHS plan made a commitment that patients should be able to receive copies of clinicians’ letters about them as of right, there has been a wealth of original research considering the outcome of this in different settings. (Appendix one)

Service users at Sussex Partnership NHS Foundation Trust have recently raised concerns that letters are not regularly copied (CC’d) to them as often as they would like and have requested that this is explored further.

1.2 Aims & Objectives
The aim of the audit is to identify how many letters, sent to the patients General Practitioner after attendance at a clinic, are also copied to the service user.

The objectives are:
- To audit 2 letters each of all Community Psychiatrists
- To interview the Admin Team Leads of all eight Assessment & Treatment Services
- To survey all Community Psychiatrists
- Report to the Counsel of Governors
- Identify further actions to take forward as a result of the findings

SECTION 2

2.1 Sample
The Admin Team Leads were asked to identify all adult and older age Psychiatrists (Consultant, Associate, Staff Grade, SHO and locum) working at the Assessment & Treatment Service. They were then asked to provide a list of two PIMs numbers for each Psychiatrist of service users who had recently been for an outpatient review or initial assessment.

<table>
<thead>
<tr>
<th>Assessment &amp; Treatment service</th>
<th>Admin Team Leaders</th>
<th>Psychiatrists</th>
<th>Letters</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West Sussex</td>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>High Weald, Lewes &amp; Havens</td>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Mid Sussex</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>1</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>1</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>1</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Adur Arun &amp; Worthing</td>
<td>1</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Western</td>
<td>1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>70</strong></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>
2.2 Data Collection

Audit of letters

All data collected from electronic clinical information systems

Measures:
- Has the letter been copied to the service user?
- If applicable, has the letter been copied to the person accompanying the service user to the appointment?
- Are there copies of other types of letters sent to the service user?

Psychiatrist - Survey

All Psychiatrists were emailed and asked to answer the following question:

Could you respond to this email with as many of the following options that apply please:

A. All letters sent to GPs are automatically copied to the patient
B. None of the letters sent to the GP are copied to the patient
C. All patients are asked, either verbally or by letter, if they want to be copied in
D. Dependent on the presentation/capacity of the patient, I decide if they will be copied in
E. Other, please give brief detail

Admin team leaders – Interviews

Telephone interviews were carried out with each of the Admin team Leaders where they were asked to describe the following.
- current practice in copying GP letters
- the process used for communicating between staff if a letter was/wasn't going to be copied, that is a service user has opted in/out
- information leaflets informing service users about opt in/opt out to receive copies of letters

The audit took place over a two week period during January 2015.

SECTION 3

3.1 Results

<table>
<thead>
<tr>
<th>Assessment &amp; Treatment service</th>
<th>Admin Team Leaders</th>
<th>Psychiatrists</th>
<th>Letters</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West Sussex</td>
<td>1 (100%)</td>
<td>1/5 (20%)</td>
<td>10 (100%)</td>
</tr>
<tr>
<td>High Weald, Lewes &amp; Havens</td>
<td>1 (100%)</td>
<td>4/5 (80%)</td>
<td>10 (100%)</td>
</tr>
<tr>
<td>Mid Sussex</td>
<td>1 (100%)</td>
<td>2/5 (40%)</td>
<td>8 (100%)</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>1 (100%)</td>
<td>8/13 (61%)</td>
<td>25/26 (96%)*</td>
</tr>
<tr>
<td>Hastings &amp; Rother</td>
<td>1 (100%)</td>
<td>8/11 (73%)</td>
<td>22 (100%)</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>1 (100%)</td>
<td>8/11 (73%)</td>
<td>16 (100%)</td>
</tr>
<tr>
<td>Adur Arun &amp; Worthing</td>
<td>1 (100%)</td>
<td>7/11 (64%)</td>
<td>20/22 (91%)*</td>
</tr>
<tr>
<td>Western</td>
<td>1 (100%)</td>
<td>3/9 (33%)</td>
<td>18 (100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8 (100%)</strong></td>
<td><strong>41/70 (58%)</strong></td>
<td><strong>129</strong></td>
</tr>
</tbody>
</table>

*duplicates provided in error*
Audit of letters

- 90 (70%) of recent clinic letters sent to the GP had not been copied to the service user.
- 3 letters had been copied to the carer/person accompanying the service user to the appointment. 63 service users were accompanied to their clinic appointment by a carer, advocate or significant other person.
- Two clinic review letters had been addressed to the service user and the GP copied in.
- 115 service users had received other correspondence from the ATS or had been copied in to letters during the previous six months. Examples are:
  - Appointment letters and other administrative information, e.g., change of location
  - Nurse reviews, initial nurse assessments
  - Psychologist assessment, reviews
  - Care plans
  - Priority assessment action plans
  - Letter to other, e.g., Department Work and Pensions, University
  - Physical health screening and intervention

While auditing the records it was noticed that in many cases previous, and fairly recent letters to GPs, had been copied to the service user. Where this occurred a different Psychiatrist had usually seen the service user in clinic.

In twenty cases, all recent review correspondence had been copied to the service user.

Psychiatrist survey

Twelve psychiatrists chose more than one option resulting in 53 answers.

<table>
<thead>
<tr>
<th></th>
<th>Responses to Psychiatrist survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>All letters sent to GPs are automatically copied to the patient</td>
</tr>
<tr>
<td>B</td>
<td>None of the letters sent to the GP are copied to the patient</td>
</tr>
<tr>
<td>C</td>
<td>All patients are asked, either verbally or by letter, if they want to be copied in</td>
</tr>
<tr>
<td>D</td>
<td>Dependent on the presentation/capacity of the patient, I decide if they will be copied in</td>
</tr>
<tr>
<td>E</td>
<td>Other, please give brief detail</td>
</tr>
</tbody>
</table>

Psychiatrist comments

I offer to send to all patients and almost all patients are sent copies of GPs letters. Not automatic though as some (very small percentage) opt not to receive copies

My letters are not automatically copied to patient. If patient requests the letter to be copied then it is sent to patient as well.

D for patients with dementia

I only send letters to patients if they have requested to be copied into the letter to GP. Consent obtained at time of initial assessment in the service

The default is all letters are copied to the pt but not without checking the pt is happy to receive, and that we have the correct address in eCPA and they are aware the letter will contain confidential info etc.

Around 95-98% of letters can then be sent if:
1. I have clinical concerns about pts understanding of consent or language or
2. There are kiddies in the house who might read it in appropriately or
3. The post isn’t secure or
4. If partner were to read it would cause problems (re affaires etc) and trigger domestic violence etc
Then in any of those types of situations it is then usually agreed with the pt they read the letter supported by the CPN or care co-ordinator, or read at GP surgery etc. I currently have 1 pt whose mental health is so brittle, and her risk profile so high that I don’t send her copies of her GP letters; but this is with both her knowledge and consent. (It has been a DOH requirement for all letters to be cc’d to pts since about 2008: I can’t imagine any clinician in our trust doesn’t?)

As much as possible I do C at each review
Sometimes there are some patients I do not feel it is appropriate to start that discussion with - so sometimes it is D as well. Due to variability of presentation it is not so easy to break down what is routine practice. There will be different issues for CAMHS, LD and old age. I am general adult in community.
I know there are some doctors who don’t always do letters.
If I have two or more reviews close together I sometimes I combine them into one letter.
I support patients being copied in and would be happy to contribute my views as to why it is important - providing it will be valuable for patients.
It may be helpful to make it clear to doctors and admin (some may need it spelt out!) that you are referring to the clinical review letters sent after appointments and not the time and date appointment letters
I support the text messaging service that has started in Bognor and we should use a lot more of

| All letters are routinely copied. However, I always check at the end to ensure they are happy with that. Most want them |
| My usual practice is to write to the patient summarizing meeting and copy to the GP. I (nearly) always discuss this in OPA and get verbal agreement. If pt prefers I write to GP and copy in pt – or not if pt prefers this. Very very occasionally if needed I write to GP – or other eg obstetrics and put on the top of letter confidential not to be shared without discussion |
| patients are being asked if they want letters sent, most of the time on new presentation, occasionally on follow-up. Admin staff has been given contradictory advice over time by a variety of people (managers/clinicians) re if they should send them out and there is no clear understanding that is universally shared by all staff members. There is no identified and agreed location where to store the info re whether letters should be sent. Even if letters were sent out at one stage, there is no process for subsequent letters other than looking at what happened with a previous letter. Letters are stored in 2 different locations on eCPA, reducing the chance of accurate continuation of preferred practice |
| In case of medication changes all patients are provided with copy of the ‘GP MEDICATION LETTER’ during the consultation (and the original is faxed to the GP on the same day or soon after) |
| In my practice the default setting is to copy all letters to the GP to the patient except if the patient or carer tell me that they do not want a copy. So I use option C asking everyone if they want a copy. |
| More of option C and D for LL,LWWD patients but more likely A and C for MAS patients. |
| Usually C or D as my patients are elderly and often suffering from dementia. They usually attend with carers so information is conveyed directly to patients and carers; they usually prefer not to receive letters as this confuses the patients or upsets them. More often than not copies of letters are declined. |
## Admin team Leaders - Survey

### Question one – What is current practice at the Assessment and Treatment Service of copying correspondence to service users

| Team leader one | Service user will receive a copy if they have requested it. The psychiatrist will discuss with the service user. Approximately 9 out of 10 service users will not receive copies. |
| Team leader two | One Consultant (and his juniors) always cc the service user. Otherwise it varies between psychiatrists. For older adults or people with Dementia, none are copied in unless specifically indicated by the psychiatrist. |
| Team leader three | All service users are given a letter on assessment, consent form for copying letters to service users and/or their carers. Once completed the form will be kept in the patients record. |
| Team leader four | All service users are given a letter on assessment, consent form for copying letters to service users and/or their carers. Once completed the form will be kept in the patients record. |
| Team leader five | The psychiatrist will usually ask the service user if they want to be copied in to letters and some will ask them to complete the consent form. One psychiatrist writes all letters to the service user and copies in the GP. |
| Team leader six | Variation in practice amongst psychiatrists. In some cases they will ask and in others they will rely on service user opt in. |
| Team leader seven | Service users are asked by the psychiatrist at the consultation if they want to be copied in. |
| Team leader eight | Not sure how the psychiatrist finds out if the service user opts in/out to receive copies. |

### Question two – What is the process used for communicating between staff if a letter was/wasn’t going to be copied, that is, a service user has opted in/out

| Team leader one | Varies by psychiatrist as some dictate the letter for the admin to type. Some write their own letters straight on to ecpa and some write handwritten notes in the file. In each case the secretary will format the letter and the psychiatrist will make it clear if the service user has opted in. |
| Team leader two | For the psychiatrist who always cc to service users we have been asked to do so for all his patients. Otherwise, they will have indicated so on dictation. All letters are approved by the Dr before being sent. |
| Team leader three | As the psychiatrist reviews the service user they dictate a letter and will add whether the service user has opted in/out to receive a copy. Admin staff are reliant on the psychiatrist for this information. |
| Team leader four | As the psychiatrist reviews the service user they dictate a letter and will add whether the service user has opted in/out to receive a copy. Admin staff are reliant on the psychiatrist for this information. |
| Team leader five | As necessary, the psychiatrist will add to dictation, ‘cc service user.’ Likewise carers as appropriate and according to whether they have asked them. |
| Team leader six | If the service user has requested to be copied or the psychiatrist has asked them, they will include on the dictation for each letter. |
| Team leader seven | The psychiatrist will add to the dictation if the service user has opted to receive letters. |
| Team leader eight | If the service user has opted in the psychiatrist will add the information to the dictation. |

### Question three – Information leaflets informing service users about opt in/opt out to receive copies of letters

| Team leader one | Do not use the consent form for copying letters to service users and/or their carers. |
| Team leader two | Do not use the consent form for copying letters to service users and/or their carers. |
| Team leader three | Use the consent form for copying letters to service users and/or their carers. |
| Team leader four | Use the consent form for copying letters to service users and/or their carers. |
| Team leader five | Some psychiatrists use the consent form and some don’t. |
| Team leader six | Do not use the consent form for copying letters to service users and/or their carers. |
| Team leader seven | Do not use the consent form for copying letters to service users and/or their carers. |
| Team leader eight | Do not use the consent form for copying letters to service users and/or their carers. |
SECTION 4

4.1 Conclusion

It is clear from the psychiatrist survey and the Admin Team Leader interviews that people believe letters are copied to service users in compliance with national recommendations. In the majority of cases Admin Team Leaders and Psychiatrists believe that there is a rigorous opt in/out process, albeit one which varies by psychiatrist and or location. In some cases this is communicated verbally and in others, service users are provided with an information sheet and consent form at initial assessment. However, the audit of letters shows that this is not the case and that the majority of service users do not receive copies of the clinic letters. It is beyond the remit of this audit to identify those cases where it would be inappropriate for people to receive this information as indicated in the DoH best practice guidance, however, it was noted that people do receive clinical information from other healthcare professionals and in many cases they receive some GP letters but not others.

It is clear that the onus is on the psychiatrist to reiterate on every dictation/letter that the service user has opted in/out from the admin support teams perspective. From the psychiatrist’s perspective, it appears they are under the impression that admin support will be responsible for ensuring this is done every time.

There are some excellent examples of where a service user has opted in to receive letters and subsequently have consistently been copied in to all correspondence. These examples have been led by psychiatrists who have had clear discussions with both the service user and their admin support team. The process is clear to all.

The conclusion from this is that people who would like to be copied in to their letters and where there is no clear rationale as to why they shouldn’t be will sometimes receive letters and sometimes they won’t. Two factors influence this. Firstly, if a service user has opted in it is not always clearly communicated between members of the healthcare and admin teams. Secondly, other than verbally, there is no capacity to store this information on electronic systems or set up reminders and in many cases staff will rely on memory.

It is beyond the remit of this audit to consider in detail, differences occurring geographically. However, it is noted that, difference in practice do occur geographically.

4.2 Recommendations

Develop a standardised process which ensures that service users can opt in/out to receive copies of the clinic letters sent to GPs in line with national best practice guidance.

It is not recommended that any further audit at this time will illicit further information, however, further analysis of the existing data on best practice examples by psychiatrist and/or location is recommended in order to promote learning and sharing. Once changes have been made it is highly recommended to re-audit in 6 months time.

Share the report with the Counsel of Governors to identify specific actions for improvement.

4.4 Action Planning

Share the report with the Counsel of Governors to identify specific actions for improvement. January 2015. To be actioned by Tim Ojo, Medical Director and Peter Lee, Company Secretary.

6. Contacts

Name: Wendy Harlow, Clinical Audit Team Leader
Team: Clinical Audit
Tel: 07787156718
Email: wendy.harlow@sussexpartnership.nhs.uk
7. Appendix 1 – Literature review

**Department of Health** Copying Letters to Patients: Good Practice Guidelines. (2003)

**Royal College of Psychiatrists** Good Psychiatric Practice: Confidentiality and Information Sharing. (2010)

**The Royal College of Psychiatrists** Copying clinical letters to patients: Guidelines for old age psychiatrists. (2004)

**Patient correspondence after outpatient appointments: What format should it take?**
Western E. Patient Education and Counseling 2011;83(2):283-284.

**An audit on copying letters to patients with learning disability.**

**Copying letters to service users with learning disabilities: Opinions of service users, carers and professionals working within learning disability services.**

**Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients.**

"Does a business-like letter written for a general practitioner meet the standards for patients?": Correction.
Mason Julian Psychiatric Bulletin 2008;32(9):--.

**Where have all the copy letters gone? A review of current practice in professional-patient correspondence.**

**Managing patients’ information in a community mental health team.**

**Copying clinic letters to psychiatric patients.**
Thair A. Psychiatric Bulletin 2005;29(9):327-329

**Copying letters to patients--will it happen?**
Boaden Ruth Family Practice 2005;22(2):141-143.

**Copying letters to patients: A study of patients' views.**

**Copying letters to patients: Issues for child and adolescent mental health services.**

**Patients' views of the letters their psychiatrists and psychologists send to referrers.**
Sharing letters with patients and their carers: Problems and outcomes in elderly and dementia care.

The benefits of letter copying in child and family mental health.

Copies of letters to GP sent to patients.
Wrate R.M. Psychiatric Bulletin 2004;28(12):--.

Copying letters to patients.
Lask Bryan Psychiatric Bulletin 2004;28(11):--.

Copying referral letters to patients: The views of patients, patient representatives and doctors.

Do patients really want copies of their GP letters? A questionnaire survey of older adults and their carers.

Evaluation of copying letters to patients.

Copying letters can help avoid communications nightmare.
Chapman Suzy BMJ: British Medical Journal 2003;326(7386):--.

Psychiatrists omit information from letters when they know patients will be sent copies.
Murray K. BMJ: British Medical Journal 2003;326(7386):--.

Patients should receive copies of letters and summaries.
Chantler Cyril BMJ: British Medical Journal 2002;325(7360):--.

Shared care? Some effects of patient access to medical communications.

Sources searched
PsycInfo (24)
Department of Health (1)
Evidence Search (2)

Search terms and notes:
communication.hw,id,sh; AND (copy* or copies) AND (letter* OR correspondence or report*).ti,ab;
QUALITY COMMITTEE SUMMARY REPORT

**SUMMARY & PURPOSE**

The last meeting of the Quality committee was held on 5 February 2015. It was chaired by Non-Executive Director, Melloney Poole. This report provides a summary of the key items discussed.

**ACTION REQUIRED BY COUNCIL MEMBERS**

Governors are invited to note the contents of the report and ask any questions.
The Selden Centre
The Committee discussed feedback received during the Care Quality Commission’s (CQC) January inspection and considered in detail matters relating to the Selden Centre. Clinical Director Vikki Baker updated the meeting on a series of actions taken in response to CQC’s concerns, and in particular in relation to the unit’s seclusion room. Assurance was tested with regard to both the issues raised and the actions taken. A further update will be presented at the next meeting on 7 May 2015.

Clinical Leadership
A detailed, lengthy and challenging discussion considered a range of concerns and issues set against the context of a recent internal Serious Incident panel review chaired by Lorraine Reid. The robustness of clinical leadership and accountability especially in relation to the adherence to required standards including the Care Programme Approach was agreed as an essential component of safe services. The Clinical Directors agreed that a meeting in which they would consider the issue and its solution in detail was essential. A further update will be presented to the May Committee meeting.

Serious Incident Reporting and Leadership
In addition to the standing agenda item showing SIs since the last meeting, the committee received an update on progress made to resolve the final SI reports outstanding. The meeting noted that progress was being made to clear the final batch and HG highlighted that work was being done with the ClinicalCommissioning Groups to accelerate their final sign off.

A wider discussion took place about how to ensure that the Trust remains on track with the sign off of final reports. Points made included the importance of joint ownership of investigations especially where two or more services are involved.

- The imperative of managers consulting clinicians
- The benefit of panel reviews
- The need to sustain grip on outstanding final reports and create new SI facilitator roles
- Raising awareness and new concepts, Safety Fridays
- The benefits of Sis being included in the appraisal system for doctors
- An update on closure of outstanding SI’s will be brought to the May meeting.

Incident Reporting Rate
The Trust’s reduction in reporting incidents was discussed. A number of initiatives to increase incident reporting were showing some improvement and the Committee noted that the Trust’s Quality Account, would include a target to increase reporting.

The meeting considered a recently published paper by Louis Appleby which drew a link between an increases rate of Patient Safety Incidents and suicide. The paper had generated national debate across mental health trusts and a summary paper will be shared at the May Committee.
Annual Planning – Quality Account Development

The committee received an update on this year’s progress noting the early engagement of key Stakeholders including Governors and Health Watch. Each meeting had generated areas for possible inclusion in 2015-16’s account;

- Sign up to Safety
- Increasing incident reporting
- Duty of Candour
- FFT
- Care Plans and GP Letters
- Outcomes
- Access to Services.

The committee listed some areas that it would like considered for inclusion;

- Reduce use of restraint.
- Mental Health Safety Thermometer.
- Physical health strategy, slips, trips, falls.
- Clear line to CQC inspection feedback and action in response
- Care Notes – outcome measures being used routinely.
- Physical Health assessment,
- Staff supervision (effectiveness of)
- Training.
- Listening in to Action.
- Adult safeguarding
- Private bed use
MENTAL HEALTH ACT COMMITTEE SUMMARY REPORT

<table>
<thead>
<tr>
<th>SUMMARY &amp; PURPOSE</th>
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<tbody>
<tr>
<td>This report summarises the discussions and papers presented at the quarterly Mental Health Act (MHA) Committee held on 6 March 2015, postponed from 12 February 2015. The MHA Committee monitors Trust compliance with the Mental Health Act 1983, the Code of Practice 2008 and associated legislation. Good governance requires the Board to be sighted of MHA activity and performance.</td>
</tr>
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<tr>
<th>ACTION REQUIRED BY COUNCIL MEMBERS</th>
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<td>This report is for information.</td>
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MENTAL HEALTH ACT COMMITTEE SUMMARY REPORT

The Committee received papers on:
- Use of the Mental health Act 1983 between 1 October 2014 – 31 December 2014
- A summary of feedback from Associate Hospital Manager (AHM) feedback forms and Tribunal feedback forms
- A report from care group service directors on MHA issues affecting respective areas of responsibility
- A briefing on the revised Mental Health Act 1983 Code of Practice, in force from 1 April 2015.

Use of the Mental Health Act 1983

The Committee received a detailed report on use of the MHA 1983 between 1 October 2014 – 31 December 2014 (hereinafter “Quarter 3”).

Quarter 3 reported areas of high activity, in particular:

- Use of s2 has remained high with 257 recorded instances compared to 242 in the same period the previous year. Of specific interest, 86% of section 2 uses were new admissions rather than re-grades.

- There was a spike in the use of S3 in West Sussex, predominantly as a result of an increase in section 2 to section 3 re-grades.

- There were a smaller proportion of section 5 detentions discharged to informal during Quarter 3. More section 5s were re-graded to sections 2 and 3.

- The Use of MHA report now contains very detailed section 136 data, including outcome data (detailed below) and data relating to under 18s detained under s136. There were 339 detentions under section 136 during the reporting period, 192 (57%) to police custody and 147 (43%) to hospital places of safety. This compares with 391 during the previous quarter, 46% of which were to hospital places of safety and 54% to police custody.

In particular, the Committee noted the following s136 outcome data: Of the 147 admissions to hospital places of safety, 23% were detained in hospital and 14% were admitted informally. Where people detained under s136 were not admitted to hospital, outcomes on discharge from the place of safety were split as follows:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Referred to CRHT</td>
<td>13</td>
<td>14%</td>
</tr>
<tr>
<td>Referred to other MHT</td>
<td>25</td>
<td>27%</td>
</tr>
</tbody>
</table>
Of the 192 admissions to police custody, 16% were detained in hospital and 9% were admitted informally. For those not admitted to hospital, outcomes on discharge from Custody were as follows:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to CRHT</td>
<td>11</td>
<td>8%</td>
</tr>
<tr>
<td>Referred to Other MHT</td>
<td>45</td>
<td>32%</td>
</tr>
<tr>
<td>Referred to GP</td>
<td>26</td>
<td>18%</td>
</tr>
<tr>
<td>Referred to Other</td>
<td>23</td>
<td>16%</td>
</tr>
<tr>
<td>NFA required</td>
<td>37</td>
<td>26%</td>
</tr>
</tbody>
</table>

- The Use of MHA report now routinely includes seclusion monitoring data, cross reported to the Quality Committee. A total of 38 incidences of seclusion were reported during the period. There has been a significant reduction in the number of incidences of seclusion on Amber (33 to 18) and Willow (25 to 11) wards during this reporting period.

- Committee were directed to review detailed data around patient transfers. There were 191 transfers of detained patients between Sussex Partnership wards, or to and from Sussex Partnership and local acute Trusts, during the reporting period. This is wholly in line with the previous quarter (194). It was specifically noted that a high proportion of internal transfers between SPFT units relate to transfer in, out and between PICUs.

**AHM Feedback reports – Key themes**

In the last quarter feedback reports from both the AHMs and the Tribunal were received; a detailed report was received by the MHA Committee. The AHMs and Tribunal gave feedback on a variety of issues. In the last quarter, a significant amount of good practice was observed relating to timeliness of reports, accuracy of information and quality of evidence provided by the patient’s care team and knowledge of the patient. Good practice and any required improvements in practice reported have been reported to the relevant care group director or resolved immediately where possible.

In particular it was noted by Committee that reported delays in the commencement of hearings were largely as a result of the late arrival of the care team or patient. There were no reported incidents of delays caused by AHMs requiring more time to read reports. This was a concern previously raised when the new process of providing report on the day of the hearing was implemented. MHA team will continue to monitor.
Revised MHA Code of Practice 2015

The Committee received a briefing on the key revisions to the MHA 1983 Code of Practice, in force from 1 April 2015.

The Committee were advised that the Trust is developing a project plan to be taken to the next Executive Assurance Committee, covering:

- Provide training across the Trust on revisions to the Code of Practice
- Increase knowledge on the MHA/MCA interface in learning disability and dementia services.

Given the intensity of training required over a short time frame, a business case will be presented for the commissioning of external trainers to provide this programme of training.
SUMMARY & PURPOSE

This report provides a summary of the papers and discussions held at the Finance and Investment Committee meeting held on the 20th February 2015.

The purpose of this Committee is to drive excellent financial performance and ensure that the Trust has an investment strategy that supports the business and is financially deliverable. The Committee is responsible for ensuring that robust scrutiny is in place, taking action to commission further work as required in the achievement of this objective.

It should be noted that a summary of the Finance and Investment Committee is reported to the Board on a monthly basis and the paper is public part of the Board and therefore the paper is available on the Trust’s website. It should also be noted that the full minutes of the meeting are circulated to all members of the Board for information.

LINK TO ANNUAL PLAN

The Annual Plan objectives this paper relates to include:-

2. Our Services & Creating New Opportunities
   2.3 Review Business Develop Strategy

4. Finance, Information & Performance
   4.1 Maintain sound financial performance to deliver financial governance and stability
   4.2 Fully deliver the agreed quality, efficiency and productivity programme
   4.3 To meet contracted levels of performance
   4.4 Review our performance and information reports and implement improvements

5. Estates & Capital
   5.1 To improve asset productivity
   5.4 To deliver the agreed capital programme
   5.5 To improve procurement activity to deliver efficiency

ACTION REQUIRED BY COUNCIL MEMBERS

The Council of Governors are asked to note the contents of this report and ask any questions of the Chair of the Finance and Investment Committee.
1.0 Executive Summary

This report provides a summary of the papers and discussions held at the Finance and Investment Committee meeting held on the 20th February 2015.

The Committee Received papers on a number of current topics including:

- Month 10 Financial position
- Agency Reduction Programme
- Cost Improvement Programme and Themed Review on Adult Services
- Forecast and Financial Recovery Plan for 2014/15
- Financial Planning for 2015/16, and update on service improvement plans for Adult and Specialist Services
- Operational Performance
- Contract Update
- Capital Expenditure Report and update on estates and facilities strategy
- Commercial Report

2.0 Introduction

The purpose of this Committee is to drive excellent financial performance and ensure that the Trust has an investment strategy that supports the business and is financially deliverable. The Committee is responsible for ensuring that robust scrutiny is in place, taking action to commission further work as required in the achievement of this objective.

The Finance and Investment Committee meet in the week before the Board meeting. The next Committee meeting is due to be held on the 20th March 2015. This report provides a summary of the meeting held on the 20th February 2015, the main areas of discussion are set out in the body of the report below.

3.0 Report

Month 10 Financial Report and Cost Improvement Plan for 2014/15

The Committee received a report on the Trust’s financial performance for month 10 noting that following on from the deterioration in the financial performance in December, January was another disappointing month, reporting a deficit in the month of £400k, after release £300k of reserves. Even after taking account of the technical adjustment for depreciation the Trust is still reporting a year to date deficit of £1.98m. The year to date deficit means that the Trust continues to report a Continuity of Services Risk Rating of 3, against a planned rating of 4.

The Committee noted that the Trust would now be reliant on additional funding support from commissioners in order to break-even. The Committee were updated on the progress being made by the Trust’s Chief Executive and Director of Finance who are in discussion with the Chief Officers and Chief Financial Officers of the Sussex Clinical Commissioning Groups (CCG) regarding additional funding to support the cost pressures facing the Trust.

The Committee held a lengthy discussion on the issues and actions that were being taken to address the areas impacting on financial performance, and asked a number of questions of the executive directors to gain assurance that the issues contributing to the financial position were being addressed. A summary of these discussions is set out below:-
• **Use of External Placement**
  There continues to be a high use of external placements as a result of bed pressures in Adult Services. In January the Trust spent £195k on external placements, taking the year to date spend to just under £1.3m. Business continuity plans are now in place, resulting in a significant reduction in external placements in the first week of February.

• **Use of Agency Staff** – the Committee noted that there was a small improvement in the cost of agency staffing in the month reducing from £657k in December to £617k in January and were updated on a number of actions being undertaken to further reduce the use of agency staff. Following the audit on use of additional staff to cover observations, focused attention has been given to ensure compliance with the Trust’s observations policy. Teams are also developing plans to reduce the use of agency staff on dementia wards, including the use of coloured wrist bands to identify patients at risk of slips, trips and falls and sensors which alert nursing staff when patients move around in their rooms.

  It was noted that recruitment to vacancies still continues to be an issue for Kent Children and Young People’s Services and work is on-going to recruit staff, as well as encouraging agency staff to apply for vacancies or work on the Trust’s bank.

  The Committee were updated on the pilot for centralisation of booking agency staff at Langley Green Hospital. The pilot has found that some areas are continuing to use paper rosters rather than e-rostering. The Human Resources team are working with the service to address this issue.

  In addition, the agency procurement process has now been concluded, with 22 agencies being appointed as preferred providers. Of these only 2 of the agencies are currently being used by the Trust and therefore there is a transition plan over the next 2 to 3 months to move to the new agencies in order not put the Trust at significant risk. The move to the national procurement framework is expecting to achieve savings of between 10 to 15%.

• **Cost Improvement Plan** – progress on the delivery of the Cost Improvement Programme (CIP) at month 10 was discussed noting that year to date £7,163k had been saved against a target of £9,807k, £2,644k less than planned. Concerns over the underperformance of the CIP were discussed, with the Committee noting that one of the main risks to the CIP was the slow progress being made on the Adult Services re-design programme, which was discussed under a separate agenda item.

• **Financial Recovery Plan** - the Committee were updated on the Financial Recovery Plan that is being implemented. The Committee noted that whilst progress was being made in a number of areas, the high use of agency staff, the pressures on the adult in-patient services and the slow progress in delivering cost improvement plans meant that it was unlikely that the Trust would be able to deliver its forecast breakeven plan without additional funding support. The Committee were also updated on the discussions that had taken place with Monitor during the Quarter 3 conference call earlier that week.

**Cost Improvement Programme Themed Review – Adult Services**

The Committee were updated on the work being undertaken in Adult Services. It was noted that this work was now moving into its third phase, to discuss the introduction of service improvement plans for 2015/16, focused on a number of key areas, including, reducing the use of external placements, the efficiency and effectiveness of community services, review of management structures, redesign of rehabilitation services and development of local schemes for each division.

The Committee noted that meetings have being set up with the divisions to work through detailed plans for next year. The first meeting was held with Coastal West Sussex on 12th February, although there was good attendance at the meeting and good discussion and engagement, it is clear that significant support is required to get Adult Services to a place where there is local ownership, management and accountability of the issues. However, these skills will be developed as the divisions are supported in their readiness to become Care Delivery Units. The Committee highlighted that service improvement plans would need to be in place from the 1st April to ensure that the full year effect of the savings is delivered in 2015/16. In addition discussions are being held with commissioners regarding addition funding for 2015/16.
Financial Planning for 2015/16
The Committee were updated on the financial planning assumptions for 2015/16. Based on current guidance the Trust is negotiating with commissioners to pass on the percentage uplift in their allocations to mental health. The issues around pay costs for 2015/16 were highlighted noting the funding of pay awards and increase in employer’s contribution to pension costs as well as the increased cost of staffing the inpatient wards and recruitment and retention payment in North West Sussex. Based on these assumptions the Trust was planning for cost improvement savings of £11.8m for 2015/16.
The Committee noted that financial planning in Specialist Services was progressing well, with the main risks for next year being in Adult and Corporate Services. The Committee requested that they are kept up to date with progress in these areas.

Operational Performance Report
The Committee received the Performance Reports for Adult and Specialist Services for Month 10, as well as the Trust wide performance report. The Committee’s discussions focused on waiting times for treatment and assessment, particularly in Kent and Hampshire Children and Young People’s Services and Adult Services in Brighton and Hove. The Committee also discussed the work being undertaken to address high readmission rates and delayed transfers of care.

Contract Update
The contract report provided the Committee with details of progress being made on the contract negotiations for 2015/16. It was noted that the Trust was still waiting for the final version of the contract for 2015/16. The Committee noted that funding for mental health services is expected to increase following amendments in the Autumn Statement, where CCGs have been instructed to ensure that as a minimum the percentage growth in their allocations is passed onto mental health. The Trust’s contract negotiations for 2015/16 are working on this premise, in order to secure additional funding to cover cost pressures, particularly in Adult Services. The Committee also noted that good progress was being made on the CQUIN programme for 2014/15, which would help improve the Trust’s financial position in addition to the quality benefits arising from the schemes.

Capital Expenditure Report
The Committee was updated on the progress being made to deliver the capital programme for 2014/15, which also included the details of asset disposals. The Committee also received a presentation on the Estates 20-20 vision, noting that the full Estates Strategy would be presented to the Committee in March.

Commercial Report
The Committee received and discussed the Commercial Report noting the current bids, an update on current tenders and new developments being considered by the Trust.

4.0 Recommendation/Action Required
The Council of Governors are asked to note the contents of this report and ask any questions of the Chair of the Finance and Investment Committee.
## PEOPLE COMMITTEE SUMMARY REPORT

### SUMMARY & PURPOSE

The People Committee met on 21 January 2015. A verbal summary of this meeting was presented by Mike Geerts at the January Board meeting. This report provides a summary of the meeting; the main areas of discussion are set out below.

### ACTION REQUIRED BY COUNCIL MEMBERS

This report is for discussion.
1. Executive Summary

The Committee received and considered papers on the following:

- Draft Staff Engagement Strategy
- Listening into Action model
- Friends and Family Test Update
- Exceptions report on Workforce Indicators
- Recruitment and retention
- Draft Workforce objectives 2015/16
- Finance and Agency Programme Updates
- Proposals for Living Wage

2. Report

2.1 STAFF ENGAGEMENT STRATEGY - PROGRESS REPORT

The Committee considered a second draft of the Staff Engagement strategy which brought together the streams of work developed through the Improvement Plan and defined aspirations for the future.

The Committee reviewed the latest draft of the strategy with in depth discussions on a number of developments already in place and new pilot models to support improvements in positive staff engagement. The Strategy will be presented to the Board in March.

2.2 FRIENDS AND FAMILY TEST

The Committee supported the proposals to use the friends and family test for all staff in future quarters rather than the specific samples used in the first two quarters of this year. The first quarter had included those staff who had been with the Trust less than a year and the second quarter, mostly in patient staff linked to the wards which had piloted the patient survey. The third quarter used the NHS staff survey. The Committee noted a 41% response (1700 staff). Results from the NHS Staff survey were expected in late February, with some helpful in depth analysis given the size of response.

2.3 LISTENING INTO ACTION MODEL

The Committee received a paper outlining this model that has been introduced across some 46 NHS trusts to date. This model would provide the framework for encouraging innovation and decision making at the front line. This model was seen as supporting the plans for the development of care delivery units.

2.4 RECRUITMENT AND RETENTION – OUTCOMES OF ASSESSMENT CENTRES

The Committee received a paper on the outcomes of the 17 assessment centres undertaken across services since April 2014. The Committee were pleased to note the competency and values based assessment approach designed in house and were advised of 379 applications received through this process. The Centres offered the opportunity for candidates to bring all their ID on the day so that offers could be made and online DBS applications made, as well as assessments by Occupational Health Services.
65% of those shortlisted were offered posts and have commenced employment. 65 are substantive staff and 130 bank. Some staff were still going through pre-employment checks.

The most significant success from this approach was Mill View Hospital for both qualified staff and health care assistants. However there had been some success in other wards, including 6 qualified nurses for dementia wards; 19 substantive staff for Langley Green and 12 community qualified posts in North West Sussex.

The Committee supported the plans for on going assessment centres and asked for more analysis and comparison of the costs this approach compared to traditional advertising and interviewing approach.

2.5 OUR PEOPLE REPORT

The Committee reviewed figures and reasons for agency spend increase in December. The Committee were updated on the pilot to centralise bank and agency bookings through the Bank Team for Langley Green. Members received the agency reduction report and noted that this would be considered in depth by the F & I Committee so focussed on recruitment and retention plans for Kent CYPS and Langley Green Hospital. The Committee also remained concerned at the ability to project any increases, including those as a result of observations.

A verbal update was also provided on work to develop a more strategic approach to recruiting and retaining newly qualified nurses (including sponsorship for training). A paper will be presented to the next People Committee.

An update on statutory and mandatory training compliance was provided with the report identifying the improvement in e-learning completions (3150) by up to 24% from November 2014. The Committee noted the new electronic system to be implemented from April 2015 which will be simpler and more personal to use but remained concerned at the current shortfall in compliance. A further report will be considered at the next Committee meeting.

2.6 DRAFT WORKFORCE OBJECTIVES 2015/16

The Committee considered a first draft of objective for 2015/16 with more work to be done on metrics. There are no Monitor workforce targets so these are all set internally.

2.7 LIVING WAGE PROPOSALS

The Committee supported, in principle, the proposals for paying all staff the living wage whilst recognising that the Board of Directors would need to make the final decision following a full discussion at the next Board meeting.

3. Recommendation/action required

To note for information.
AUDIT COMMITTEE SUMMARY REPORT

SUMMARY & PURPOSE

This report provides a summary of the papers and discussions held at the Audit Committee meeting held on 16<sup>th</sup> March 2015.

The Audit Committee is responsible for monitoring and reviewing matters such as the integrity of financial statements, internal controls and overseeing the internal audit function. It is also focused on providing assurance to the Board that the systems and processes are functioning effectively (so that the Board is discharging its duty) and that those committees that are reviewing quality information in more detail are doing so effectively. The Audit Committee’s annual work plan is designed to cover these responsibilities and sets the agenda for each meeting, which is built around the following areas:-

- Risk Management
- Governance
- Financial Controls
- Accountability
- Self-Assessment

Minutes of the meeting are circulated to all Board members.

LINK TO ANNUAL PLAN

The Audit Committee acts on behalf of the Board to review audits designed to assess whether or not management’s systems and processes are working effectively and support the delivery of the Trust’s annual plan. Additionally the Committee reviews management’s preparation of the Board Assurance Framework, to assess whether or not risks and mitigating controls are properly reported and reflect the Trust’s planned activities.

ACTION REQUIRED BY COUNCIL MEMBERS

The Council of Governors are asked to note the contents of the summary report and address any questions to the Chair of the Audit Committee.
Audit Committee Summary Report

1.0 Executive Summary

This report provides a summary of the papers and discussions held at the Audit Committee meeting held on 16th March 2015. Michael Chambers was the governor observer at the meeting. Colm Donaghy, the Trust’s Chief Executive attended the meeting, in accordance with the requirement for the Chief Executive to attend the Audit Committee on an annual basis.

The Committee received papers including:

- **Risk Management** - progress reports from the Internal Auditors and Local Counter Fraud Service and draft annual plan for 2015/16.
- **Governance** - Draft Annual Governance Statement
- **Financial Reporting & Controls** - Update on 2014/15 Annual Accounts and External Audit
- **Accountability** - Update on Salary Overpayments
- **Self-Assessment** - Review of on-going development of Audit Committee Members

2.0 Introduction

This report summarises the detailed discussions of the Committee. Information which is confidential to the Trust or its employees is not included in the report.

3.0 Report

**Progress Reports from Internal Auditors and Local Counter Fraud Service**

The Committee received three reports:

(i) **Update on progress being made to deliver the internal audit plan** - the Committee received an update on the progress the Internal Auditors were making in delivering their audit plan for 2014/15. Since the last Committee meeting two audits have been finalised; Payments to Staff, which was rated Green for Payroll, but Amber/Red for salary overpayments and Location Visits which was also rated Amber/Red. In addition two advisory reviews on the Board Assurance Framework and the Lindridge Centre had also been completed. In reaching conclusions on their audit work, the auditors found that in the main that the Trust had appropriate procedures, but that these were not being consistently followed. The Committee had an in depth discussion of means to improve compliance to procedures by staff at all levels in the Trust and proposed a number of management actions to be swiftly implemented to ensure rigorous governance within the forthcoming operation structure utilising Care Delivery Units and their compliance and performance frameworks.

It was agreed that the Lindridge Centre report was unsatisfactory and that recommendations arising from the previous report had not been implemented quickly enough. The Committee requested that these points be addressed by the Nursing Home Development Board with a report back to the next Committee meeting.

The report also provided an update on sector information and briefings, including The Dalton Review and the consultation on proposed updates to the Monitor Risk assessment Framework.
(ii) **Draft Head of Internal Audit Opinion** – the Committee received the draft Head of Internal Audit Opinion for 2014/15, noting that based on the work undertaken in 2014/15 the Internal Auditors have issued a draft opinion of “significant assurance”, subject to the final audits to be completed by the end of the financial year, weaknesses have been identified, and in five areas only partial assurance could be provided:

- salary overpayments,
- location visits,
- appraisals,
- recruitment and
- budgetary control.

Each of these reports have been reviewed by the Committee along with priority actions and follow up audits.

(iii) **Internal Audit Work Plan for 2015/16** – the Committee received the draft Internal Audit work plan for 2015/16, noting that the draft plan had been prepared following discussions between the Head of Internal Audit and the Executive Director of Finance and Performance and that the plans build upon the auditors three year strategy and incorporates sector based risks and those areas of risk identified by the Trust. It also builds on the discussions held the Audit Committee meeting in January. The plan has been shared with the Executive Management Team and once finalised will be made available to the Council of Governors. The Committee requested that further consideration be given to:

- quality, scope and ability to deliver cost improvement plans
- governance, compliance and performance structures for Care Delivery Units and
- review of the contractual management and implementation of Carenotes, the Trust’s new clinical information system.

The Committee received two reports from the Trust’s Local Counter Fraud Service (LCFS).

(i) **Update on progress being made to deliver the LCFS plan** – the Committee received an update on the proactive work being undertaken, including fraud awareness, salary overpayments, Care Quality Commission Fit and Proper Persons Test.

The Committee was updated on the reactive work being undertaken and the progress being made to investigate cases and bring them to conclusion. There has been some good joint work with the Internal Auditor on the locations visits and payroll audits.

(ii) **LCFS Work Plan for 2015/16** - the Committee received the draft Internal Audit work plan for 2015/16, noting that the approach to developing the LCFS plan was based on the analysis of emerging internal and external fraud risks. The methods used by fraudsters continue to develop and the Trust must stay vigilant to these. The emphasis of the work plan is focused on proactive work, working closely with the Trust’s managers and staff in those areas considered to be at risk from fraud and bribery. The work plan includes provision for reactive work where investigation into specific cases is required.

**Update on 2014/15 Annual Accounts and External Audit**

The Committee received a report setting out the timetable for the preparation of the Annual Accounts and Report for 2014/15. The Committee also received a verbal update from PricewaterhouseCoopers, the Trust’s External Auditors. The Auditors informed the Committee that they had recently completed their interim audit and there were no significant issues arising from the audit.

A number of operational and transactional issues were in discussion with the audit team as they may have a bearing on the audit including the issue of the CQC Wave Inspection report on the Trust.
**Compliance Matters**
In view of the significance of the compliance issues under review by the Committee it was agreed that the regular compliance report should be expanded across all of these areas, include a summary assessment by unit of compliance standards and report on implementation of improvement actions.

**Salary Overpayments Update**
The Committee received an update on the actions being taken to reduce salary overpayments and noted that there had been a reduction in overpayments over the last three months. Management reported that the LEAN Project Team are now working on this issue with the objective of improving this process. The new electronic starter and leaver forms are being implemented early in the new financial year, which should also help reduce salary overpayments.

**Other Reports**
The Committee also received and discussed a number of other papers including the draft Annual Governance Statement for 2014/15 and a review of Losses and Special Payments and debtor and creditor balances over £5k and 180 days old.

### 4.0 Recommendation/Action Required

The Council of Governors are asked to note the contents of the summary report and address any questions to the Chair of the Audit Committee.

### 5.0 Next Steps

This report is for information. A private meeting of the Audit Committee is due to be held on 29th April 2015 to review the draft accounts, with the next full meeting of the Committee due to be held on the 18th May 2015.
Internal audit strategy 2014/2015 - 2016/2017

Presented at the Audit Committee meeting of: 16 March 2015
Contents

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1 Introduction

Our approach to developing your internal audit plan is based on analysing your corporate objectives, risk profile and assurance framework as well as other, factors affecting Sussex Partnership NHS Foundation Trust in the year ahead including changes within the sector.

1.1 Background

The NHS is having to rethink how care is delivered to ensure that people receive the right care, in the right place, at the right time. Sussex Partnership NHS Foundation Trust is rising to this challenge by providing responsive care closer to home, that enables people to stay healthy and independent and reduce avoidable hospital admissions.

The Trust is now one of the most influential, effective and well-respected mental health trusts in the country and, as a teaching trust of Brighton and Sussex Medical School; they have developed a national reputation for leading-edge research.

1.2 Vision

Their Purpose is improving people’s lives through the best possible experience of our services.

Their Values of Respect, Listening, Partnership, Integrity and Optimism inform their Behaviours, which they describe in their Better by Experience commitments.

Their mission is threefold

- To deliver consistent high quality evidence based care and treatment;
- For patients and staff to recommend Sussex Partnership as a place where they would be happy for their family and friends to work or be treated;
- To work in a spirit of openness and partnership.

1.3 Objectives

- Quality and the Experience Of Patients
- Our Services and creating new opportunities
- A learning organisation (Teaching And Research)
- Finance, Information And Performance
2 Developing the internal audit strategy

We use your objectives as the starting point in the development of your internal audit plan.

2.1 Risk management processes

We have evaluated your risk management processes and consider that we can place reliance on your risk registers / assurance framework to inform the internal audit strategy. We have used various sources of information (see Figure A below) and discussed priorities for internal audit coverage with the following people:

- Director of Finance and Performance

The plan based on their comments and the initial comments of the Audit Committee at its meeting in March 2016.

Based on our understanding of the organisation, and the information provided to us by the stakeholders above, we have developed an annual internal plan for the coming year, and a high level strategic plan.
How the plan links to your strategic objectives

Each of the reviews that we propose to undertake is detailed in the internal audit plan and strategy within Appendices A and B. In the table below we bring to your attention particular key audit areas and discuss the rationale for their inclusion or exclusion within the strategy.

As well as assignments designed to provide assurance or advisory input around specific risks, the strategy also includes: time for tracking the implementation of actions and an audit management allocation. Full details of these can be found in Appendices A and B.

<table>
<thead>
<tr>
<th>Area</th>
<th>Reason for inclusion or exclusion in the audit plan/strategy</th>
<th>Link to strategic objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Planning &amp; Resourcing</td>
<td>As the greatest percentage of the Trust’s costs are staff related, it is important that Workforce related issues are clearly considered both in terms of maximising the usage of the staff employed and providing a safe place of Care. Therefore, we will review the Trust’s arrangements for Workforce Planning and Resourcing to ensure an effective workforce is in place to deliver the services required and prevent and reduce the risk of significant harm to Service Users. In addition we will ensure the Staff Limits set within the budget can be mapped back to the Workforce Plan and are not exceeded during the year.</td>
<td>7.7 To Ensure We Have A Workforce Plan To Meet The Needs Of The People We Serve And Deliver Our Plans</td>
</tr>
<tr>
<td>Supervision For All Staff</td>
<td>As the Trust is impacted on a high vacancy factor there becomes a lack of capacity/demands on time to enable supervision to be a priority and this could have a detrimental effect on patient safety and also quality of clinical care. We will review processes to record supervision to demonstrate that it is taking place and effective actions are being taken where extra support and/or training is required. We will consider the accuracy, completeness and timeliness of reporting of compliance.</td>
<td>3.5 - Ensure Access To Supervision For All Staff Including Clinical Supervision For All In Clinical Roles</td>
</tr>
<tr>
<td>Cost Improvement Planning</td>
<td>Annually the challenge is becoming harder to drive through financial efficiencies without impacting on the quality of services to be provided. Mental Health based Trusts are particularly exposed in this area as Clinical Commissioning Groups look to drive through their own savings, therefore effective Cost Improvement Planning is essential. We will review a sample of CDU plans early in the financial year to assess the robustness of the assumptions for finance and quality and determine the likelihood of delivery, suitability of accountability and assess the degree of stakeholder engagement.</td>
<td>4.2 Fully Deliver The Agreed Quality, Efficiency And Productivity Programme</td>
</tr>
<tr>
<td>Area</td>
<td>Reason for inclusion or exclusion in the audit plan/strategy</td>
<td>Link to strategic objective</td>
</tr>
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<tr>
<td>Backlog Maintenance &amp; Capital Schemes</td>
<td>As the Trust has limited availability of revenue funding and the focus is on service delivery and patient care it becomes difficult to reduce funds to maintain and improve environment were services are provided. We will consider the overarching setting of the Capital Programme, Business Case processes and the management and reporting against the programme. Additionally for a sample of projects we will undertake testing in regards to value for money around the capital procurement. In addition, we will focus on how the backlog maintenance is prioritised and delivered.</td>
<td>5.4 Deliver The Agreed Capital Programme &amp; 5.3 Total Backlog Maintenance Reduced</td>
</tr>
<tr>
<td>Agency</td>
<td>Annually the challenge is becoming harder to drive through financial efficiencies and Agency cost in 14/15 was still one of the Trust main areas of overspend/standardisation and compliance issues. This area will link in with the Trust CIP and also Workforce planning. We will the review the new arrangements for managing Agency across the Trust in particularly at ward/unit level. This will build on our work performed in 14/15 assessing the pilot at Langley Green.</td>
<td>7.3 Improve The Quality Of Services By Reducing The Use Of Agency Staff</td>
</tr>
<tr>
<td>Location Visits</td>
<td>As the Trust continues to have concerns around standardisation and compliance through the Trust. We will use Performance Outlier data, as well as through discussion with Management, and visit a sample of locations to confirm that policy and processes are operating as intended. The specific focus of these reviews may vary depending upon the level of risk and the nature of the services provided from each location. This could include follow up on the recent CQC findings to ensure implementation or specific focus on other performance outliers to understand the root cause of such performance.</td>
<td>Management Concern - Standardisation &amp; Compliance. This is to run through all audits</td>
</tr>
<tr>
<td>New Clinical Information System</td>
<td>There is a significant roll-out of the clinical information system. The CEO is chairing the steering group and there is also a director-led project board. The Trust is at the early stage of the roll-out and would like assurance over the set-up? The provider has won a number of other contracts and the Trust would like assurance they remain capable to deliver when they said they would.</td>
<td>6.3 To Improve the Clinical Information Systems</td>
</tr>
</tbody>
</table>
2.2 Working with other assurance providers

The Audit Committee is reminded that internal audit is only one source of assurance and through the delivery of our plan we will not, and do not, seek to cover all risks and processes within the organisation.

We will however continue to work closely with other assurance providers, such as external audit and Local Counter Fraud to ensure that duplication is minimised and a suitable breadth of assurance obtained.
3 Internal audit resources

Your internal audit service is provided by Baker Tilly Risk Advisory Services LLP. The team will be led by Nick Atkinson - Partner, supported by David May as your Client Manager.

3.1 Fees

Our anticipated fee to deliver the plan of 190 days is £76,243 (excluding VAT).

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>190</td>
<td>190</td>
</tr>
<tr>
<td>Fees</td>
<td>£75,117</td>
<td>£76,243</td>
</tr>
</tbody>
</table>

3.2 Conformance with internal auditing standards

Baker Tilly affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS). Further details of our responsibilities are set out in our internal audit charter within Appendix D.

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our Risk Advisory service line commissioned an external independent review of our internal audit services in 2011 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF) published by the Global Institute of Internal Auditors (IIA) on which PSIAS is based.

The external review concluded that “the design and implementation of systems for the delivery of internal audit provides substantial assurance that the standards established by the IIA in the IPPF will be delivered in an adequate and effective manner”.

3.3 Conflicts of Interest

We are not aware of any relationships that may affect the independence and objectivity of the team, and which are required to be disclosed under internal auditing standards.
4 Audit committee requirements

In approving the internal audit strategy, the committee is asked to consider the following:

• Is the Audit Committee satisfied that sufficient assurances are being received within our annual plan (as set out at Appendix A) to monitor the organisation’s risk profile effectively?

• Does the strategy for internal audit (as set out at Appendix B) cover the organisation’s key risks as they are recognised by the Audit Committee?

• Are the areas selected for coverage this coming year appropriate?

• Is the Audit Committee content that the standards within the charter in Appendix D are appropriate to monitor the performance of internal audit?

It may be necessary to update our plan in year, should your risk profile change and different risks emerge that could benefit from internal audit input. We will ensure that management and the audit committee approve such any amendments to this plan.
## Appendix A: Internal audit plan 2015/2016

<table>
<thead>
<tr>
<th>Audit area</th>
<th>Scope for 2015/16</th>
<th>Audit days</th>
<th>Proposed timing</th>
<th>Estimated audit committee date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk based assurance</strong></td>
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<tr>
<td>Clinical Audit</td>
<td>The purpose of the review is to provide the Trust with assurance that robust arrangements are in place for the identification, undertaking and reporting of clinical audit areas. This should ensure that the organisation is auditing mandated areas, identifying those which are appropriate to meet other targets or objectives, notably CIP schemes, and is less focused on areas of personal interest to clinicians. We should ensure that there is challenge of the use of finite resources that Trusts typically expend on clinical audit. We will also be looking to provide assurances that each audit report is subject to a process of follow to ensure that weaknesses identified have been addressed and that the desired improvements in outcomes have been realised.</td>
<td>8</td>
<td>July 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td><strong>Workforce Planning &amp; Resourcing</strong></td>
<td>We will review the Trust’s arrangements for Workforce Planning and Resourcing to ensure an effective workforce is in place to deliver the services required and prevent and reduce the risk of significant harm to Service Users. In addition we will ensure the Staff Limits set within the budget can be mapped back to the Workforce Plan and are not exceeded during the year.</td>
<td>10</td>
<td>December 2015</td>
<td>March 2016</td>
</tr>
<tr>
<td>Knowledge and Skills Framework (KSF)</td>
<td>Management concern - We will review the Trust approach at establishing the new Knowledge and Skills Framework to assess staff performance that allows people to move up the scale which also focuses on behaviours.</td>
<td>8</td>
<td>June 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td>Audit area</td>
<td>Scope for 2015/16</td>
<td>Audit days</td>
<td>Proposed timing</td>
<td>Estimated audit committee date</td>
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</tr>
<tr>
<td><strong>Supervision For All Staff</strong></td>
<td>We will review processes to record supervision to demonstrate that it is taking place and effective actions are being taken where extra support and/or training is required. We will consider the accuracy, completeness and timeliness of reporting of compliance.</td>
<td>10</td>
<td>August 2015</td>
<td>November 2015</td>
</tr>
<tr>
<td><strong>Cost Improvement Planning</strong></td>
<td>We will undertake an early review of the cost improvement programme to consider the assumptions underpinning the programmes both from a qualitative and financial perspective, stakeholder engagement and deliverability. We will consider a sample of the CDU CIP plans.</td>
<td>10</td>
<td>June 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td><strong>Contract Management</strong></td>
<td>We will review the Trust processes in place to ensure it is fulfilling its contracts in line with the requirements. We will focus on a sample of high value contracts to ascertain if the Trust is obtaining the services and VFM.</td>
<td>10</td>
<td>September 2015</td>
<td>November 2015</td>
</tr>
<tr>
<td><strong>Backlog Maintenance &amp; Capital Schemes</strong></td>
<td>We will consider the overarching setting of the Capital Programme, Business Case processes and the management and reporting against the programme. Additionally for a sample of projects we will undertake testing in regards to value for money around the capital procurement. In addition, we will focus how the backlog maintenance is prioritised and delivered.</td>
<td>10</td>
<td>October 2015</td>
<td>January 2016</td>
</tr>
<tr>
<td><strong>Performance Management – Data Quality</strong></td>
<td>For a sample of key performance figures reported to the Board we will review the underlying data quality to provide assurance that the information reported is accurate.</td>
<td>10</td>
<td>January 2016</td>
<td>March 2016</td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td>We will the review the new arrangements for managing Agency across the Trust. This will build on our work performed in 14/15 assessing the pilot at Langley Green.</td>
<td>12</td>
<td>June 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td><strong>IT Security</strong></td>
<td>We will assess the vulnerability of Trust to cyber-attacks and or unauthorised access to their systems. Also we will assess were their partner businesses and third-party suppliers are subject to the same level of scrutiny as hackers.</td>
<td>9</td>
<td>November 2015</td>
<td>January 2016</td>
</tr>
<tr>
<td>Audit area</td>
<td>Scope for 2015/16</td>
<td>Audit days</td>
<td>Proposed timing</td>
<td>Estimated audit committee date</td>
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<tr>
<td>Mobile Devices</td>
<td>We will review Trust arrangements for managing these risks associated with mobile devices and arrangements for ensuring that appropriate safeguards are in place for handling and processing patient data on mobile devices.</td>
<td>9</td>
<td>July 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td>Care Delivery Units</td>
<td>The Trust is amending its structure and it will be critical that there is suitable governance embedded in the new structure. This review will consider whether the CDUs understand responsibilities from a compliance perspective and what is required for them to become accredited.</td>
<td>12</td>
<td>July 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td>Clinical Information Systems – Roll Out – Project Management</td>
<td>There is a significant roll-out of the clinical information system. The CEO is chairing the steering group and there is also a director-led project board. The Trust is at the early stage of the roll-out and would like assurance over the set-up? The provider has won a number of other contracts and the Trust would like assurance they remain capable to deliver when they said they would.</td>
<td>10</td>
<td>June 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td><strong>Core assurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial &amp; Payroll Systems</td>
<td>We will conduct a risk assessment on the function and test the higher risk elements to give assurance over the adequacy of the financial controls.</td>
<td>15</td>
<td>November 2015</td>
<td>January 2016</td>
</tr>
<tr>
<td>IG Toolkit</td>
<td>The purpose of the review is also to examine the attainment levels submitted for a number of requirements within the toolkit, with a view to providing an opinion on the appropriateness of the information submitted and the adequacy of the documentation held to support these scores. This also ensures that if investigated the Trust can demonstrate actual compliance.</td>
<td>8</td>
<td>January 2016</td>
<td>March 2016</td>
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<td></td>
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<td>August 2015</td>
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<td>March 2016</td>
<td>May 2015</td>
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<tr>
<td>Audit area</td>
<td>Scope for 2015/16</td>
<td>Audit days</td>
<td>Proposed timing</td>
<td>Estimated audit committee date</td>
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<td>------------------------------------------------</td>
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<tr>
<td>Other internal audit input</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Action tracking – Follow up of recommendations</td>
<td>To meet internal auditing standards and to provide management with on-going assurance regarding implementation of recommendations.</td>
<td>9</td>
<td>Throughout the Year</td>
<td>Each Meeting</td>
</tr>
<tr>
<td>Contingency</td>
<td>For coverage of risks and changes in assurance needs as these arise during the year. To be agreed in advance with Trust Management.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit management</td>
<td>This will include:</td>
<td>20</td>
<td>Throughout the Year</td>
<td>Each Meeting</td>
</tr>
<tr>
<td></td>
<td>• Planning</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Ongoing liaison and progress reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preparation for and attendance at Audit Committee; and</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Development and publication of the annual internal audit opinion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>190</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B: Internal audit strategy

<table>
<thead>
<tr>
<th>Proposed area for coverage</th>
<th>Scope and Associated risk Area</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk based assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>1.3 Effective Services - Clinical audit not seen as a priority within stretched services.</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults &amp;</td>
<td>1.1 Safe Services - Lack of capacity to sustain the level and intensity of activity required to</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Children at risk</td>
<td>deliver initiatives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning the Lessons</td>
<td>1.2 A Positive Patient Experience - Sustainable changes not delivered in response to negative</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>(Incidents &amp; Complaints)</td>
<td>feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whistleblowing</td>
<td>1.2 A Positive Patient Experience - Sustainable changes not delivered in response to negative</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge and Skills</td>
<td>7.2 All Staff To Have A Meaningful Annual Appraisal And A Personal Development Plan - Managers</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Framework (KSF)</td>
<td>not prioritising and staff Not pursuing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance – Well Led</td>
<td>8.7 Develop A Detailed 5 Year Strategic Plan For 2015/16 And Beyond - Failure to engage staff,</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Framework Preparedness</td>
<td>Commissioners, Governors and public.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Delivery Units</td>
<td>8.1 Develop A Model Of Earned Autonomy - Culture change not fast enough.</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Workforce Planning &amp;</td>
<td>7.7 To Ensure We Have A Workforce Plan To Meet The Needs Of The People We Serve And Deliver Our</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resourcing</td>
<td>Plans - Plan requires workforce planning expertise and capacity.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Improvement Programmes</td>
<td>4.2 Fully Deliver The Agreed Quality, Efficiency And Productivity Programme - Lack of detailed</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>project plans to support each cost improvement scheme.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgetary Control &amp;</td>
<td>4.1 Maintain Sound Financial Performance To Deliver Financial Governance And Stability - Failure</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Planning</td>
<td>to deliver agreed financial recovery plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Management Concern – Risk that with CCGs looking to drive efficiencies that this will impact on</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>the income available for delivery of services at the Trust.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement and</td>
<td>4.1 Maintain Sound Financial Performance To Deliver Financial Governance And Stability - Failure</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with Standing</td>
<td>to deliver agreed financial recovery plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposed area for coverage</td>
<td>Scope and Associated risk Area</td>
<td>2014/15</td>
<td>2015/16</td>
<td>2016/17</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Contract Management</td>
<td>4.1 Maintain Sound Financial Performance To Deliver Financial Governance And Stability - Failure to deliver agreed financial recovery plans.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance Management</td>
<td>4.3 To Meet Contracted Levels Of Performance - Failure to deliver performance indicators as set out in contracts to deliver services, which poses financial and reputational risk to the Trust (BAF)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Backlog Maintenance &amp; Capital Schemes</td>
<td>5.4 Deliver The Agreed Capital Programme &amp; 5.3 Total Backlog Maintenance Reduced - Limited availability of revenue funding to maintain/improve environment.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Appraisals</td>
<td>7.2 All Staff To Have A Meaningful Annual Appraisal And A Personal Development Plan - Managers not prioritising and staff Not pursuing.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Recruitment</td>
<td>7.4 Reduce The Time To Hire Target To Improve First Impressions Of The Trust And Reduce Level Of Vacancies - Capacity and resource in both HR and operational services to deliver.</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Absence Management</td>
<td>7.5 To Improve Staff Health And Wellbeing - Potential benefits available not properly recognised by organisation.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>3.3 To Ensure Explicit Linkage Between Training For Future And Existing Workforce And The Delivery Of Care Packages And Care Pathways</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Supervision For All Staff</td>
<td>3.5 - Ensure Access To Supervision For All Staff Including Clinical Supervision For All In Clinical Roles - Lack of capacity/demands on time to enable supervision to be a priority Supervision not seen as a priority for some professional groups.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Agency &amp; E-Rostering</td>
<td>7.3 Improve The Quality Of Services By Reducing The Use Of Agency Staff - Non delivery of agency reduction programme.</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Standardisation &amp; Compliance</td>
<td>Management Concern Using Performance Outlier data, as well as through discussion with Management, we will visit a sample of locations to confirm that policy is operating as intended. The specific focus of these reviews may vary depending upon the level of risk and the nature of the services provided from each location.</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Proposed area for coverage</td>
<td>Scope and Associated risk Area</td>
<td>2014/15</td>
<td>2015/16</td>
<td>2016/17</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Data Quality</td>
<td>4.3 To Meet Contracted Levels Of Performance - Failure to deliver performance indicators as set out in contracts to deliver services, which poses financial and reputational risk to the Trust.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IT Contract Management</td>
<td>6.1 To Deliver The Benefits Of The Investment In Information Technology - Failure to engage staff in use of new technology to realise benefits.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>IT Project Management</td>
<td>6.3 To Improve The Clinical Information Systems - Scale and pace of challenge of Delivery.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>IT Security</td>
<td>6.3 To Improve The Clinical Information Systems &amp; 6.2 To Improve The Security Of Information - Scale and pace of challenge of delivery</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mobile Devices</td>
<td>6.3 To Improve The Clinical Information Systems &amp; 6.2 To Improve The Security Of Information - Scale and pace of challenge of delivery.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Joint Ventures</td>
<td>8.7 Develop A Detailed 5 Year Strategic Plan For 2015/16 And Beyond - . Failure to engage staff, Commissioners, Governors and public.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Core assurance**

- **Financial Ledger and Feeder Systems** covers: General Ledger, Income and Debtors, Creditor payments, Cash Receipting and Treasury Management, Payment to Staff.
  - We have previously reviewed all the financial systems and will agree with the Trust on a cyclical based or high level risk based approach for systems or areas to be reviewed. ✓ ✓ ✓

- **Governance: CQC Registration and compliance**
  - Audit of the management processes followed by the Trust to ensure that the Trust is continuing to continually challenge its compliance with the CQC standards. ✓

- **IG Toolkit**
  - Provided as a key requirement for audit coverage to provide assurance on the accuracy and robustness of the data used in the IG Toolkit submission. ✓ ✓ ✓

- **Board Assurance Framework & Risk management**
  - Review of the Trust’s risk management and use of its assurance framework. Core requirement of the Head of Internal Audit Opinion. ✓ ✓ ✓

**Other Internal Audit input**
<table>
<thead>
<tr>
<th>Proposed area for coverage</th>
<th>Scope and Associated risk Area</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action tracking</td>
<td>To meet internal auditing standards and to provide management with on-going assurance regarding implementation of recommendations. To allow for additional audits to be undertaken at the request of the audit committee or management based on changes in assurance needs as they may arise during the year.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Contingency</td>
<td>This will include:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Planning</td>
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<td></td>
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<tr>
<td></td>
<td>• Development and publication of the annual internal audit opinion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit Management</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendix C: Factors influencing the internal audit strategy

The diagram below highlights the planned internal audit coverage against the changing risk environment. This analysis allows us to ensure that the type and level of coverage proposed meets the organisation’s assurance needs for the forthcoming and future years.
Appendix D: Internal audit charter

1.0 Need for the charter

1.1 This charter establishes the purpose, authority and responsibilities for the internal audit service for Sussex Partnership NHS Foundation Trust. The establishment of a charter is a requirement of the Public Sector Internal Audit Standards (PSIAS) and approval of the charter is the responsibility of the audit committee.

1.2 The internal audit service is provided by Baker Tilly Risk Advisory Services LLP ("Baker Tilly"). Your key internal audit contacts are:

<table>
<thead>
<tr>
<th>Partner</th>
<th>Client manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Nick Atkinson</td>
</tr>
<tr>
<td></td>
<td>David May</td>
</tr>
<tr>
<td>Telephone</td>
<td>(0)7730 300307</td>
</tr>
<tr>
<td></td>
<td>(0)7972004131</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:Nick.atkinson@bakertilly.co.uk">Nick.atkinson@bakertilly.co.uk</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:David.may@bakertilly.co.uk">David.may@bakertilly.co.uk</a></td>
</tr>
</tbody>
</table>

1.3 We plan and perform our internal audit work with a view to reviewing and evaluating the risk management, control and governance arrangements that the organisation has in place, focusing in particular on how these arrangements help you to achieve its objectives.

1.4 An overview of the individual internal audit assignment approach and our client care standards are included at Appendix E and F of the audit plan issued for 2015/16.

2.0 Role and definition of internal auditing

"Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organisation’s operations. It helps an organisation accomplish its objectives by introducing a systematic, disciplined approach in order to evaluate and improve the effectiveness of risk management, control, and governance processes".

*Definition of Internal Auditing, Institute of Internal Auditors and the Public Sector Internal Audit Standards*
2.1 Internal audit is a key part of the assurance cycle for your organisation and, if used appropriately, can assist in informing and updating the risk profile of the organisation.

3.0 Independence and ethics

3.1 To provide for the independence of Internal Audit, its personnel report directly to the Nick Atkinson (acting as your head of internal audit). The independence of Baker Tilly is assured by the internal audit service reporting to the Chief Executive, with further reporting lines to the Director of Finance and Performance.

3.2 The head of internal audit has unrestricted access to the Chair of Audit Committee to whom all significant concerns relating to the adequacy and effectiveness of risk management activities, internal control and governance are reported.

Conflicts of Interest

3.3 Conflicts of interest may arise where Baker Tilly provides services other than internal audit to Sussex Partnership NHS Foundation Trust. Steps will be taken to avoid or manage transparently and openly such conflicts of interest so that there is no real or perceived threat or impairment to independence in providing the internal audit service. If a potential conflict arises through the provision of other services, disclosure will be reported to the audit committee.

3.4 The nature of the disclosure will depend upon the potential impairment and it is important that our role does not appear to be compromised in reporting the matter to the audit committee. Equally we do not want the organisation to be deprived of wider Baker Tilly expertise and will therefore raise awareness without compromising our independence.

4.0 Responsibilities

4.1 In providing your outsourced internal audit service, Baker Tilly has a responsibility to:

- Develop a flexible and risk based internal audit strategy with more detailed annual audit plans which align to the corporate objectives. The plan will be submitted to the audit committee for review and approval each year before work commences on delivery of that plan.
- Implement the audit plan as approved, including any additional reviews requested by management and the audit committee.
- Ensure the internal audit team consists of professional internal audit staff with sufficient knowledge, skills, and experience.
Establish a quality assurance and improvement program to ensure the quality and effective operation of internal audit activities.

Perform advisory activities where appropriate, beyond internal audit's assurance services, to assist management in meeting its objectives.

Bring a systematic disciplined approach to evaluate and report on the effectiveness of risk management, internal control and governance processes.

Highlight control weaknesses and required associated improvements and agree corrective action with management based on an acceptable and practicable timeframe.

Undertake action tracking reviews to ensure management has implemented agreed internal control improvements within specified and agreed timeframes.

Provide a list of significant performance indicators and results to the audit committee to demonstrate the performance of the internal audit service.

Liaise with the external auditor and other relevant assurance providers for the purpose of providing optimal assurance to the organisation.

5.0 Authority

5.1 The internal audit team is authorised to:

- Have unrestricted access to all functions, records, property and personnel which it considers necessary to fulfil its function.
- Have full and free access to the audit committee.
- Allocate resources, set timeframes, define review areas, develop scopes of work and apply techniques to accomplish the overall internal audit objectives.
- Obtain the required assistance from personnel within the organisation where audits will be performed, including other specialised services from within or outside the organisation.

5.2 The head of internal audit and internal audit staff are not authorised to:

- Perform any operational duties associated with the organisation.
- Initiate or approve accounting transactions on behalf of the organisation.
- Direct the activities of any employee not employed by Baker Tilly unless specifically seconded to internal audit.
6.0 Key Performance Indicators (KPIs)

6.1 In delivering our services we require full cooperation from key stakeholders and relevant business areas to ensure a smooth delivery of the plan. We proposed the following KPIs for monitoring the delivery of the internal audit service:

<table>
<thead>
<tr>
<th>Delivery</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audits commenced in line with original timescales agreed in the internal audit plan.</td>
<td>Conformance with the Public Sector Internal Audit Standards.</td>
</tr>
<tr>
<td>Draft reports issued within 10 working days of debrief meeting.</td>
<td>Liaison with external audit to allow, where appropriate and required, the external auditor to place reliance on the work of internal audit.</td>
</tr>
<tr>
<td>Management responses received from client management within 10 working days of draft report.</td>
<td>Response time for all general enquiries for assistance is completed within 2 working days.</td>
</tr>
<tr>
<td>Final report issued within 3 days from receipt of management responses.</td>
<td>Response to emergencies such as concerns of potential fraud with 1 working day.</td>
</tr>
<tr>
<td>Completion of internal audit plan by the end of the financial year.</td>
<td>Consideration of the feedback and scores from client satisfaction questionnaires.</td>
</tr>
</tbody>
</table>

7.0 Reporting

7.1 An assignment report will be issued following each internal audit assignment. The report will be issued in draft for comment by management, and then issued as a final report to management, with the executive summary being provided to the audit committee. The final report will contain an action plan agreed with management to address any weaknesses identified by internal audit.

7.2 The Head of Internal Audit will issue progress reports to the Audit Committee and management summarising outcomes of audit activities, including follow up reviews.

7.3 As your internal audit provider, the assignment opinions that Baker Tilly provides the organisation during the year are part of the framework of assurances that assist the board in taking decisions and managing its risks.
7.4 As the provider of the internal audit service we are required to provide an annual opinion on the adequacy and effectiveness of the organisation’s governance, risk management and control arrangements. In giving our opinion it should be noted that assurance can never be absolute. The most that the internal audit service can provide to the board is a reasonable assurance that there are no major weaknesses in risk management, governance and control processes. The annual opinion will be provided to the organisation by Baker Tilly Risk Advisory Services LLP at the financial year end. The results of internal audit reviews, and the annual opinion, should be used by management and the Board to inform the organisation’s annual governance statement.

8.0 Data Protection

8.1 Internal audit files need to include sufficient, reliable, relevant and useful evidence in order to support our findings and conclusions. Personal data is not shared with unauthorised persons unless there is a valid and lawful requirement to do so. We are authorised as providers of internal audit services to our clients (through the firm’s Terms of Business and our engagement letter) to have access to all necessary documentation from our clients needed to carry out our duties.

8.2 Personal data is not shared outside of Baker Tilly. The only exception would be where there is information on an internal audit file that external auditors have access to as part of their review of internal audit work or where the firm has a legal or ethical obligation to do so (such as providing information to support a fraud investigation based on internal audit findings).

8.3 Baker Tilly has a Data Protection Policy in place that requires compliance by all of our employees. Non-compliance will be treated as gross misconduct.

9.0 Fraud

9.1 The audit committee recognises that management is responsible for controls to reasonably prevent and detect fraud. Furthermore, the audit committee recognises that internal audit is not responsible for identifying fraud; however internal audit will assess the risk of fraud and be aware of the risk of fraud when planning and undertaking any internal audit work.

10.0 Approval of the internal audit charter

10.1 By approving this document, the annual plan, the audit committee is also approving the internal audit charter.
Appendix E: Our internal audit approach to an assignment

Each audit will be planned individually to ensure that the scope addresses the risks facing your organisation, and is therefore a useful source of assurance, providing assurance on the controls that you rely on to manage your risks and deliver your objectives.

We will meet with appropriate staff to understand the area under review and will then send you an Assignment Planning Sheet for your comment and sign off, so that we can discuss and agree the scope of each review; this provides the Audit Sponsor with an opportunity to comment on the scope of each audit. We will agree the audit date at the start of the year and you will receive a planning sheet at least four weeks before the audit commences.

Once the scope has been agreed, our audit fieldwork is carefully planned to ensure that we thoroughly test the right controls. Should we identify any major issues during the review, we will bring these to the attention of management straight away. We will keep you informed through the audit, and our team will be happy to answer any questions you may have. We will provide a list of information we will need when we issue the planning sheet so that you can prepare for the audit.

Before the internal audit team leaves site, we will hold a debrief meeting to discuss our findings with you and agree actions to address any control weaknesses.

Therefore, there will be no surprises when you receive the draft internal audit report, and you have an opportunity to comment on the report before it is issued for wider circulation.

Each formal assurance report will contain a clear opinion, so you know instantly if your risk management of this area is effective.

Every internal audit report contains an action plan which is completed by management. Once the action plan is completed the report is issued as a final report. This provides the Audit Committee with a clear view of management’s response to each finding, and also enables action tracking. As part of the annual plan we will undertake follow up work to provide the Audit Committee with an overview of progress in implementing actions that management have agreed.

CLIENT CARE STANDARDS

Discussions with senior staff at the client take place to confirm the scope six weeks before the agreed audit start date.

Key information such as the draft assignment planning sheet are issued by Baker Tilly to the key auditee four weeks before the agreed start date.

The lead auditor to contact the client to confirm logistical arrangements two weeks before the agreed start date.

Fieldwork takes place on agreed dates with key issues flagged up immediately.

A debrief meeting will be held with audit sponsor at the end of fieldwork or within a reasonable time frame.

Two weeks after a debrief meeting a draft report will be issued by Baker Tilly to the agreed distribution list.

Management responses to the draft report should be submitted to Baker Tilly.

Within three days of receipt of client responses the final report will be issued by Baker Tilly to the assignment sponsor and any other agreed recipients of the report.
Appendix F: Overview of internal audit assignment opinions

For internal audits classed as “risk based assurance” reviews (compared with advisory input), we use four opinion levels as shown below. Each assignment report will explain the scope of the review, and therefore the context and scope of the opinion.

- Taking account of the issues identified, the Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).

- Taking account of the issues identified, the Board can take partial assurance that the controls to manage this risk are suitably designed and consistently applied. Action is needed to strengthen the control framework to manage the identified risk(s).

- Taking account of the issues identified, the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).

- Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.
For further information contact

Name Nick Atkinson – Partner - Baker Tilly Risk Advisory Services LLP
nick.atkinson@bakertilly.co.uk
Direct Line: +44 (0)20 3201 8028
Mobile: +44 (0)7730 300307

Name David May – Audit Manager – Baker Tilly Risk Advisory Services LLP
david.may@bakertilly.co.uk
Phone: +44 (0)1293 843121
Mobile: +44 (0)7972004131
Report from Charitable Funds

<table>
<thead>
<tr>
<th>SUMMARY &amp; PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>This paper gives a summary from the last Charitable Funds Committee Meeting held on 9th Feb 2015.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION REQUIRED BY BOARD MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Information - The Council of Governors are asked to note the contents of this report and ask any questions. In particular a discussion within the council about how engagement with Governors could be developed would be valued.</td>
</tr>
</tbody>
</table>
1.0 Executive Summary

1.1 The last meeting of the Charitable Funds Committee was held on the 9th February 2015, this report provides a summary of the meeting.

1.2 Grant Making – It was confirmed that the General Fund now has four application deadlines per year and applications will not be considered outside those deadlines. This also applies to applications for own account research funding.

1.3 Fundraising Applications - £23,810 has been pledged from Rockinghorse Children’s Charity to support the Chalkhill activities programme, and the following three applications are in progress:
   - Sport England – Outdoor games area at Hellingly
   - Skills Funding Agency investment for Community Learning Mental Health Pilots
   - Department of Health Voluntary Sector Investment Fund – supporting Turning Point’s application to increase uptake of IAPT services for older people in East Sussex and Aldingbourne Trust’s applications to support people with complex learning disabilities to have a voice within their care planning process.

1.4 Research Update from Mark Hayward - Mark Hayward updated the committee on the Heads On funded own account research studies. Updates were given on the following studies that we funded in 2013 and 2014:
   - The development of a Mindfulness App for CAMHS.
   - The Like Mind project which is a pilot of self-help mindfulness based intervention, combined with CBT for mild to moderate depression.
   - The learning disability peer supporter study, which has been withdrawn as the research team have disbanded. None of the £14,999 allocated for this study was drawn upon.
   - The Psychosis Research Group study, aiming to develop a measure so that young people can assess their own mental wellbeing and see if they need help.

An update was also given on a Mindfulness for Voices study, for which the pilot study had been funded by Heads On. Based on the success of the pilot study, NIHR funding was secured to complete a randomised control trial involving 108 patients. The main finding was that patients showed significant improvement in depression after the course of therapy, an effect was stable even after 6 months. The points of learning that came from this study were that researchers neglected to fully pay attention to what depression means for this client group, the effects of the therapy diminished over time (the “bounce” effect) and that all participants showed improvements afterwards, not just those in the control group.

Concerns were raised about studies that had not/were not currently drawing down funds. For the withdrawn study, M Hayward assured the board that this was an exceptional case, and for the current studies he will make enquiries with the Research Finance Lead Phillipa Case.
It was agreed that the mindfulness study should be mentioned in both the Trust and Charity’s annual reports.

1.5 **Application for funding for Paro the robotic seal** – Penny Dodds presented her application to the committee for funding to roll out the use of Paro the robotic seal in dementia inpatient units across the Trust. The committee approved funding for 5 additional Paros, one for each dementia ward. The funding is subject to conditions regarding price negotiation, maintenance being funded by inpatient settings themselves, a reporting schedule to be agreed and promotion of Heads On’s support. It will be supported by a student doing a full time masters in clinical research, researching the clinical outcomes of people with dementia interacting with Paro.

1.6 **Strategy Away Day (2nd Feb) Feedback** – The need for targeted fundraising appeals was discussed. It was agreed that clinical teams will put forward projects that they want funding, and the committee will develop criteria to decide which of these would be funded.

1.7 **Financial Summary**: The Financial Summary and Investment Update were noted by the Committee. It was agreed that amendments to the draft investment policy would be feedback and a final version would be presented at the next meeting. The committee also agreed to getting a new bank account set up with Santander.

### 2.0 Recommendation/Action Required

The Council of Governors are asked to note the contents of this report and ask any questions of the Clinical Academic Director.

### 3.0 Next Steps

We will be taking forward the themes from our Away Day (1.6 above). In particular:

- Ensuring that we deliver on our fundraising priorities in accordance with our strategy.
- Making sure we are meeting our financial plan and ensuring the growth of the general fund through community fund raising activities and grant applications.
- Improving engagement with the charity through sign up of volunteers and engagement with of stakeholders.
SUMMARY & PURPOSE

The Nomination and Remuneration Committee met on 26 March 2015 to consider the annual appraisal of performance of the Chair and Non-Executive Directors.

All Governors were asked through the ‘Governors Update’ to provide their feedback and comments on the performance of the Chair and Non-Executive Directors. The Lead Governor then provided a summary of these comments to the appraiser for inclusion in the appraisal meetings which were held during March.

The outcome of each appraisal was discussed by the Committee and it agreed that much good work had been undertaken by each of the Non-Executive Directors during the past 12 months. It was quite evident that Council representation at each Board Committee has helped Governors this year to better understand the work of Non-Executive Directors; this was reflected in some of the feedback. A verbal report from the Committee will be presented to the Council of Governors in private.

The Committee also discussed succession planning for Non-Executive Directors, acknowledging that Tim Masters will come to the end of his second 3-year term in early 2016. The Committee will meet in May 2015 to begin the process for this.

In addition, the Committee will use the meeting in May 2015 to consider the tendering process for the Trust’s external auditors. Council members will recall that in January the Council agreed to extend the contract of PWC to complete the audit of 2014/15 and so it will need to make a decision in time for the audit at the end of 2015/16.

ACTION REQUIRED BY COUNCIL OF GOVERNORS

To note the good work of the Nomination and Remuneration Committee and ask members questions, as required.
STRATEGIC REVIEW – OUR 2020 VISION

SUMMARY & PURPOSE

This is the third paper to the Council of Governors on our Strategic Review, the output of which is Our 2020 Vision. The purpose of this paper is to:

1) Share the draft of Our 2020 Vision and invite further comments on the content.

2) Summarise the contribution of members of the Council of Governors in the Strategic Review and how this has helped to shape Our 2020 Vision.

3) Advise on the next steps.

1. Our 2020 Vision

I have attached a draft of Our 2020 Vision and invite further comments from the Council of Governors. As the Vision is going to Trust Board on 25 April for approval I ask that comments are provided to me by e-mail or phone no later than 13 April 2015. This will provide time to consider them in advance of finalising the document for Trust Board. My contact details are listed at the end of this paper. Please note the draft is going through final editing and this also includes the imagery used.

2. Contribution and influence of the Council of Governors in developing Our 2020 Vision

The contribution of members of the Council to shaping Our 2020 Vision has been very much welcomed and I am grateful to the time and support members have given. Involvement in the strategic review process has included the following:

a) Joint Board and Council of Governors Review Days

On the 10 November 2014 we had our first Joint Board and Council of Governors Review Day since launching the strategic review. We used the time on the day to work in groups to discuss and explore three questions.

1) How do we use the expertise of the Council of Governors and membership to connect with local communities?

2) What does the future look like for Sussex Partnership?

3) What are the key questions we need to ask service users, carers, staff, commissioners and the public?
Appendix 1 is a summary of the session, which was previously circulated to members of the Council. The outputs from the first day shaped the strategic choices the Trust Board considered and the further involvement from members of the Council in internal and external engagement.

On the 9 February 2015 we had our second joint review day and at this session we explored the priorities for our strategic goals and also what differentiates us as a provider. The output from this is included at appendix 2. The outputs from each of these days have shaped the Board’s thinking and development of Our 2020 Vision.

b) Vision Workshop
A representative from the Council attended the workshop held with staff on shaping the new vision statement.

c) Public engagement events
Representatives from the Council attended and participated in the public engagements events we held. These sessions proved invaluable listening sessions. The support of members of the Council was very helpful and welcomed by the members of public they engaged with.

3. Next steps
Our 2020 Vision will be finalised and go to Trust Board in April for approval. The Transformation Programme Board is developing the detailed implementation plan and this will be shared with the Council of Governors.

We plan to hold on-going public engagement events and launch Our 2020 Vision in May / June. It will be beneficial to have members of the Council of Governors at these events and assist with the presentations and engagement of the public and our partners in our new vision.

SPECIFIC POINTS FOR GOVERNORS

a) Comments welcomed on the draft by 13 April.

b) The role of the Council in shaping and influencing Our 2020 Vision.

c) Involvement from the Council of Governors welcomed in our on-going public engagement.

ACTION REQUIRED BY COUNCIL MEMBERS

The Council of Governors is review the draft of Our 2020 Vision and return comments by 13 April.
1.0 Report

Collated themes from workshop discussions at Joint Session of the
Council of Governors and Board of Directors - 10 November 2014

1) How do we use the expertise of the Council of Governors and membership to connect with local communities?
   - Recognise the expertise of the Council in developing strategy
   - Ensure feedback is provided to the Board
   - Able to identify gaps in service
   - Get involved with specific tasks
   - Council to be involved and briefed on the work of the Board on the strategy and have the ability to comment and contribute
   - Attend and support public and trust engagement events
   - Staff Governors to seek the views of staff
   - Council to define some ‘red lines’ – what would be out of the question
   - To help involve and engage our Trust membership

2) What does the future look like for Sussex Partnership?
   - Greater focus on local communities
   - More partnerships – we can't do everything
   - Want to avoid getting too big (spread of geography)
   - Consider new areas of health and care to develop
   - A corporate function that can provide continuity to support local delivery e.g. business partner model
   - Outcomes focused
   - Providing prevention, early intervention and wellbeing services
   - More partnership with GPs and third sector
   - Patient led – meeting the needs of our customers
   - Clear about what we do and stand for e.g. standards and values
   - Breaking down silos

3) What are the key questions we need to ask service users, carers, staff, commissioners and the public?
   - What is working well?
   - What should we do less of or stop?
   - What should we do more of?
Joint Session of the Council of Governors and Board of Directors – 9 February 2015

1. Introduction
A joint session of the council of governors and board of directors was held on 9 February. A focus of the session was to share the emerging themes from the strategic review process; this process has engaged a wide variety of stakeholders, staff, service users, commissioners and the public. The key findings so far were presented to the group and then participants joined small facilitated groups to provide direct feedback on two areas:
- what differentiates us from other providers and hence what we would want to be known for and
- the emerging strategic themes

2. What differentiates us
There were a number of perspectives which will be set out before summarising.

There was a strong emphasis on wanting to be defined by our consistent delivery of good services, very much coming from a patient perspective. The main strands of good quality care were thought to be:
- A clear user and carer focus
- Being caring and acting with genuine integrity
- Innovation
- Local services
- Being trusted

There was a lot of discussion on seamless services, personalisation and putting patients first. In particular, the recent work in developing peer support and recovery focused services were cited as real strengths.

Reputation and trust were seen as important defining aspects we need to improve and consistently apply. There was discussion about how organisations can be defined by examples of poor practice and so it is incredibly important to be consistent and hot standards as often as possible.

Partnership was another strong theme both in terms of strong integrated working with partner agencies and a hopeful recovery approach.

The suggested main theme for which we would want to be defined going forward is:

Working in partnership to consistently deliver caring, recovery focused services
3. Feedback on the emerging strategic themes / goals

**Service of choice** – we need to be a service people choose in the increasingly competitive market
- Quality and outcomes
- Being seen as a leading provider in the south east
- Expand the recovery model and approach
- Offering a valued, relevant and flexible service

**Partnerships** – we need to develop our partnerships and ensure these are based on mutual trust and effective outputs
- Partnerships with patients
- Focus on outcomes
- Seen as an expert in our field
- Integration with physical healthcare
- Act as a broker across the whole pathway
- Ensure partnership are real
- Use our knowledge to influence others and promote our good work
- The new Care Delivery Units will be an enabler for deeper partnership working

**Communications** – effective communications are essential to build trust, communications is a two way process which means we must seek out and listen to feedback
- Communicate with service users and carers
- Communicate with partners
- Communicate effectively with each other in the organisation
- More ownership / responsibility for communication across the whole pathway, this greatly improves the patient experience
- Listening and learning
- Being transparent, particularly around outcomes and experience

**Integration**
- We have a great deal of experience and opportunity to lead the way in terms of integration and act as a system integrator
- In order to deliver integrated services it is crucial to build trust with partners
- We should locate staff in community teams and primary care services in order to facilitate integration and seamless services
- Offer a one-stop shop approach both in partnership and as a single provider

**Specialist knowledge and expertise**
- Promote use and share innovation and best practice
- We need to make sure we are harnessing what we already have in terms of expertise and make sure it is consistently applied
- To achieve consistency we need to set standards and put in place a service improvement programme to achieve these goals
- Workforce development is a key factor in developing and sharing expertise

**Sustainability**
- Financial control
- Workforce development and skill mix
- Effective and clear models of care
- Meeting expected standards and the requirements of regulators
- Building trust
- Research and innovation
- Being realistic about what we can achieve and ensuring we deliver
- Flexible models of care
4. Next steps
The outputs of the joint session between the Council of Governors and Board of Directors, which are set out in this paper, will be incorporated into the trust strategy and the plan for the year ahead.

### 4.0 Recommendation/Action Required

The Council of Governors is review the draft of Our 2020 Vision and return comments by 13 April.
Our 2020 Vision:
Outstanding care and treatment you can be confident in.
Our purpose

We work with you, support your recovery and provide you with the care and treatment you need, when you need it.

Our vision

Outstanding care and treatment you can be confident in.

Our values

- Respect and dignity
- Commitment to the quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

Our goals

1. Safe, effective, quality patient care
2. Local, joined up patient care
3. Put research, innovation and learning into practice
4. Be the provider, employer and partner of choice
5. Live within our means
About 70% of mental health service users feel the need to conceal their illness.

87% of mental health service users across England reported experiencing discrimination in at least one aspect of life in the preceding 12 months.

It's estimated there will be nearly 8 million more adults in the UK by 2030.

If prevalence rates for mental disorders stay the same, that means 2 million more adults with mental health problems feel the need to conceal their illness.

75% of people with mental illness receive no treatment.

Three-quarters of people with physical disorders receive treatment, while only a quarter of people with mental disorders do so.

About 7,500 young people develop psychosis every year in England.

Coronary heart disease is more common in people with schizophrenia (4%) and bipolar disorder (5%) than in the rest of the population (3%).

£70 - 100 billion per year:
The cost of mental illness to the UK economy.

Up to 30% of consultations in primary care are with people who are experiencing Medically Unexplained Symptoms and have no clear medical diagnosis.

1 in 10 children and young people aged 5 – 15 have a clinically diagnosable mental disorder.

The life expectancy for people with mental illness can be up to 15-20 years less on average than for people without mental illness.

75% of people with mental illness receive no treatment.


*Rethink. **Department of Health, July 2014. †Mental Health Foundation.
Across Sussex over 25,000 people currently have dementia. This is set to rise to 30,000 over the next 10 years.

Sussex has the highest number of older people of any area in the UK. It therefore has more people living with dementia proportionally than anywhere else in the country.

We receive about 17,000 new referrals to our services in a year.

In a year, there are about

3,600 admissions to our hospital services

52,000 outpatient appointments

430,000 community appointments

At the moment we are treating about 22,700 patients within our adult services.

Forensic services: last year we admitted 76 people to our low and medium secure unit.

Our learning disability services provided specialist health interventions to

3,416 in 2014.

This included referrals for complex physical health as well as challenging behaviour and mental health.

Of this number, about 5,000 have psychosis and 9,600 have a cognitive impairment.

Last year more than 5,000 children and young people started treatment with us in Sussex.

Last year more than 4,300 children and young people started treatment with us in Kent and Medway.
We provide NHS care and treatment for people living in south east England. Our mental health services provide care and treatment for people with conditions such as psychosis, depression, anxiety, dementia and personality disorder.

Our specialist learning disability services provide community and hospital care for people with complex health needs which can’t be met by other services. We have a number of services that provide very specialist care for people with complex health conditions and social care needs.

We provide care in people’s homes, in specialist clinics, hospitals, GP surgeries and prisons. Our services are aimed at children, young people and adults of all ages and many are provided in partnership.

Our purpose
We work with you, support your recovery and provide you with the care and treatment you need, when you need it.

Our strategy in summary

Focus on patients and carers:
Providing high quality local and specialist care for people where and when they need it.

Mind and body:
Working in partnership to treat physical and mental health together.

Making it easy:
Showing people where to go for help, being clear about our services and how to access them.
How we want to improve

We provide a range of specialist mental health, learning disability, prison health and substance misuse services. We also provide care and treatment for people with physical health problems such as chronic pain and diabetes affecting their mental health.

Our 5,000 staff provide services for nearly three million people across Brighton and Hove, East and West Sussex, Hampshire, Kent and Medway. We work with social care and provide some integrated services together in partnership.

As well as treating illness, we are exploring new ways to help people stay well and become experts in managing their own mental health and wellbeing. Our involvement in recovery colleges, developed and run in partnership with other organisations and people who have used services, is one way we are doing this.

Everything we do is influenced by five ways of working which we call our ‘better by experience’ commitments: we welcome you, we hear you, we work with you, we are helpful and we are hopeful.

Making sure everyone is treated fairly and valued equally is very important to us. We believe people should be able to achieve their full potential regardless of age, disability, race, nationality, ethnic or national origin, gender, gender identity, religion, sexual orientation or domestic circumstances.

Over the last few years we have been working hard to bring research, teaching and clinical services more closely together to benefit patients. We are undertaking more research than ever before and are helping train people who will become the health and social care professionals of tomorrow. We have been granted university hospital status in recognition of our work in this area.

“patients, carers and the public have told us we need to listen more”

We believe we are at our best when we work with others to bring our specialist expertise together for the benefit of patients. We also accept that we cannot improve care to the highest level of quality and deliver the outcomes patients want on our own. We’ve developed strong working relationships with other NHS organisations, GPs, local councils, police, voluntary organisations, social enterprises and private sector providers.

We want to build on our achievements as a specialist mental health provider and bring physical and mental health care more closely together. As well as treating a specific condition, we will work in partnership with others to provide joined up care that looks after the ‘whole’ person. This includes making sure that people with mental ill health get access to physical health care.

We want to help reduce the stigma and discrimination associated with mental illness. We are committed to ensuring mental health care is resourced and promoted positively to help improve the health and wellbeing of the local communities we serve.

Our patients, staff, carers and public have told us we need to listen more and be better at responding to what people tell us. We need to treat every patient as an individual and provide care based on their needs and circumstances.

To achieve Our 2020 Vision, we need to create and maintain an organisational culture that feels safe, supportive and trusting and which encourages staff to take risks where this is in the best interests of patients and their families.

Recruiting, retaining and supporting high quality staff will help us provide the very best possible care.

We need to challenge ourselves, be open to new ideas and have the conviction to put good ideas into practice, evaluate the outcomes and share the learning where this will improve things for patients. This will help us provide the kind of services where you would feel confident and reassured about your family and friends being treated, and where you would want to be treated yourself if you became unwell.
Our 2020 Vision describes what we will do over the next five years to improve the services we provide to patients. To help us plan this we’ve spoken to people about what they think of our services, the care we provide and what they would like us to do in future.

We’ve also looked at wider issues that will affect the services we provide now and in the future. One example is that Sussex has the highest number of older people in the UK. This means there are more people here living with dementia proportionally than anywhere else in the country.

We’ve carefully considered the feedback we’ve had from organisations, like the Care Quality Commission, which are responsible for monitoring the quality of services we provide. This provides us with thorough, expert and independent analysis about where we need to do better and how we compare with other NHS services.

We’ve looked long and hard at where we know we need to improve. Carers and people who have used our services have told us, for example, that they can find it hard to know where to get help and sometimes feel like they are being passed around ‘the system’. Whilst the way mental health services are provided is complex and involves a lot of organisations, this is something patients and carers shouldn’t need to worry about. They shouldn’t even notice. Our job is to work so well with our partners that people only notice the quality of care and support they are receiving. At the same time, it should be clear about where people should go if they have concerns or complaints at any time about their care.

Many of our services have developed new ideas to improve services for patients, but we are not as good as we should be at learning from these positive examples and putting them into practice elsewhere.

More broadly, it can take up to 20 years in the UK for the learning from healthcare research to be used to benefit patients. We want to help reduce that gap. The mind and body continue to be treated separately, whereas it would be better for patients if physical and mental health care were brought more closely together.

The NHS is treating more patients than ever before. People are living longer and have very high expectations of health and social care services. We want to do the very best we can to help the patients and local communities we serve. Our 2020 Vision sets out how we will do this. Rather than being set in stone, it is something we will continue to review and discuss with the people who use our services, who work here and work with us.

What’s Our 2020 Vision about?

Outstanding care and treatment you can be confident in.
We have identified five strategic goals which will steer us towards where we want to be in five years time. We will continue to review and refresh these, working in partnership with people who use our services, who work here and work with us, including our commissioners.

1. Safe, effective, quality patient care
2. Local, joined up patient care
3. Put research, innovation and learning into practice
4. Be the provider, employer and partner of choice
5. Live within our means
Goal 1: deliver safe, effective, and consistently high quality patient care

We want to deliver safe, effective, consistently high quality care for patients. This involves treating everyone as an individual, focusing on their strengths and helping them with their recovery and wellbeing. We want to earn a reputation for achieving the best outcomes for patients and for supporting carers and families. To do this we need to excel at getting help to people at the earliest opportunity, preventing crisis and providing specialist support to those who need it.

We have an important role to play in preventing suicide, working with our partners in local communities and people we provide care to.

Our electronic clinical notes system will ensure that the information we collect from patients is up to date and stored safely. It will prevent patients from having to keep providing the same information to different staff, will help us manage individual patients’ care more effectively and provide us with detailed information about the effectiveness of the treatment we provide.

We believe it is always possible to do things better and will support continuous improvement and learning. We will create a culture where people feel able to speak out about concerns and we will learn from when things go wrong.

Our ambitions for 2020

- Provide the safest NHS mental health services in England.
- Use recovery as a guiding principle, inspiring hope and supporting people to achieve their goals and live meaningful lives.
- Provide care and treatment based upon reliable evidence that it works and where its impact on patients and their families is measured and published.
- Enable patients and carers to access the services they need easily, encouraging them to choose to receive their care from Sussex Partnership.
- Develop and maintain a culture of openness, transparency and innovation that values everyone's contribution in delivering high quality patient care.
- Have standard operating protocols across all our clinical services to help reduce and eliminate variation in outcomes and the experience of the care we provide.
- Provide services in clean, safe environments.
- Always look after the physical health needs of people using our services.
Our services are about people. Putting people at the centre of our plans means we will:

- understand the needs of our local communities, adapt our services to meet them and continue to develop specialist services for the south east region where we are best placed to do this
- listen to, involve and be accountable to patients, carers, governors and members
- work alongside people with lived experience of mental illness to promote recovery, positive mental health and wellbeing in our local communities
- deliver pathways of care that join up physical and mental health care, working in partnership with other health and social care providers
- provide clear information about what we do and make it as easy as possible for people to access our services, seven days a week. If someone needs help and we are not best placed to provide it, we will help direct them to the right place
- be clear, open and explicit about what we do and the support we provide. We will make it easy for people to understand what they can expect from our services and when. We will describe this in language which is clear, without being patronising, and which does not include jargon
- only do what we are best placed to do. This may mean we stop doing some things where others can do it better
- work in partnership to support our local communities
- behave and make decisions which are guided at all times by our values.

Goal 2: local, joined up patient care

Goal 3: put research, innovation and learning into practice

We will consistently put the learning from research into practice for the benefit of patients by developing, evaluating and delivering new ways of providing care and treatment.

We will involve patients in research and keep them informed about how this research is being used.

We believe it is always possible to do things better and will support continuous improvement and learning.

We will be bold and creative in finding ways to improve patient care. We will encourage and learn from the creativity of staff, patients and carers to achieve this, and will lead the way in developing and measuring new ways of providing care.

Our ambitions for 2020

- We capture all ideas and use the best of these to improve care. Where possible and appropriate, we will standardise our services.
- Clinicians and managers use the latest techniques and learning from elsewhere to continuously improve care and outcomes for patients.
- We identify, celebrate, share and learn from positive practice, both from within our own services and from elsewhere.
- Learning from research is used consistently and systematically to improve quality.
- We are seen as an expert provider of evidence-based mental health and wellbeing services.
- Five years after being granted university status in 2015, we can demonstrate how we have continued to bring research, teaching and clinical care more closely together for patient benefit.
If we build a reputation for providing the best care, outcomes and patient experience then people will choose to use our services if they need specialist mental health support. We will also be the provider that commissioners want to work with, having earned a reputation for understanding and meeting the needs of local communities. One of the things that will help us achieve this is recruiting, supporting and keeping hold of high quality staff.

We value working with others because it helps us deliver better care and improve outcomes for patients, carers and families. It encourages us to learn from what others do, reflect on how we work, challenge the way we do things and help us provide better care. Because of the way we approach partnership, we will be an organisation that others want to work with.

There are many examples where our staff provide compassionate, high quality care. We want to do this consistently and make a positive difference to every person we see and speak to. We will support staff and help them learn new skills so they have opportunities to develop their career. We will also provide a working environment where people feel it is OK to ask for help and able to raise concerns. By feeling positive about working here, staff will always be professional, provide consistently high quality care and act as ambassadors for Sussex Partnership.

**Goal 4: be the provider, employer and partner of choice**

Our ambitions for 2020

- We have created the conditions where people feel able at any time to speak out about concerns.
- Our staff consistently say they feel supported and satisfied in their role. They describe Sussex Partnership as a place that’s good to work and somewhere where they would feel confident about their family and friends being treated.
- We have a healthy and engaged workforce and are recognised as a valued local employer.
- We have strong, valued partnerships and the organisations we work with speak positively about us.
- We excel at providing individuals and teams with training, development and ongoing learning opportunities.
- Where people have a choice about where to receive health care and treatment, they choose us.
- We work with people who have lived experience of mental illness on designing, developing and improving services.
- We will use digital technology across our services to support access and self-management.
- Our care delivery units will provide services where staff are empowered to decide how best services can meet the needs of local populations.
Living within our means involves being responsible with public money and using our resources wisely. Maintaining clinically and financially sustainable services means we will:

- make best use of the resources we have by being efficient and innovative in everything we do
- find ways to manage the demands that clinical teams face so that our services are both clinically and financially sustainable, which may involve more working in partnership with other organisations
- constantly identify opportunities to develop and improve services, particularly in areas where patients’ needs are not being met as well as they should be
- plan the use of our finances to help us develop local and regional services
- talk with our commissioners, patients, staff and other partners about what we do well, need to do differently (and how) or stop doing.

We will achieve all our contractual, statutory and regulatory requirements. In simple terms, this means we will deliver on the service and financial plans we have said we will achieve each year, and the care we provide will be safe, effective and efficient. Like all public services, we have to deliver significant savings. This means we have to challenge ourselves about what we can do differently with reduced resources, at the same time as being bold and ambitious with our plans for change. Our plans on finance and quality will help us ensure we are doing the right things at the right time.

**Goal 5: living within our means**

**Our ambitions for 2020**

- Clinically and financially sustainable services.
- Deliver financial plans whilst improving care and outcomes.
- An investment plan that has supported transformation.
- We will reduce our carbon emissions by 20,000 tonnes. As well as helping the environment, this will save money so we can spend more on healthcare.
How we will put our vision into practice

**What we do**
We have a number of plans to help us achieve our goals

- Patient and carer involvement, engagement and experience
- Staff engagement and wellbeing
- Research and teaching
- Equality, diversity and human rights
- Technology in action
- Business intelligence
- Corporate service development
- Quality account
- Estates and facilities
- Admin service review

**Clinical service strategy**
- Specialist services
- Adult services

**Work streams**
- Quality improvement
- Care delivery units and clinical academic groups
- Standardised clinical care pathways
- Value, behaviours and staff wellbeing

**Team working**
Effective team working and development

**What we are going to do**
Overseen by our **Transforming Care and Outcomes** board, led by our chief executive

- **Goal 1:** Safe, effective, quality patient care
- **Goal 2:** Local joined up patient care
- **Goal 3:** Put research, innovation and learning into practice
- **Goal 4:** Be the provider, employer and partner of choice
- **Goal 5:** Live within our means

**Where we want to be**
How we’ll know we’ve achieved our goals...

- Patient/carer satisfaction: evidenced through direct feedback and survey results
- Effective care and treatment: evidenced through outcomes for individual patients and clinical services
- Staff satisfaction: evidenced through direct feedback, survey results, high retention rates, low sickness absence rates
- Our reputation: evidenced by the strength of our collaborative working relationships with a wide range of partner organisations

**How we work**

**Our values and behaviours**
This includes how we listen, learn and improve in response to patient, carer, staff and other feedback
How we will know we’re on track...

- People will spend less time in hospital and receive care at home wherever possible
- People will feel involved in planning their care
- People will have more advice and support with their own recovery
- Carers will receive the support they need
- More people with long term physical health problems such as diabetes will receive the care and treatment they need for their mental health and wellbeing
- People with severe and enduring mental health problems receive better physical healthcare
- People we support and our staff will feel listened to and contribute to improvement
- Learning from incidents will be shared and used as a matter of routine to improve care
- Innovation, positive practice and learning will be evident in everything we do.
Our values and behaviours

Our organisational values and behaviours are about how we work, act and make decisions.

We think our existing values need updating and that now is a good time to do this given we are looking ahead at what we will do over the next 5 years.

One of the points that came through in discussions about ‘Our 2020 Vision’ is that people feel positive about working in and receiving care from the NHS. With this in mind, we think it would make sense to adopt the NHS constitution values which have been developed nationally.

There may be a case for making some changes to the wording of these values to make them work for us. For example, we believe it would be good to add ‘carers’ to the ‘working together’ value. This is something we would like to discuss with you over the coming months.

- Respect and dignity
- Commitment to the quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

This approach builds on our ‘better by experience’ commitments: we welcome you, we hear you, we work with you, we are helpful and we are hopeful.

Our values and behaviours should be clear, accessible, understood and, most importantly, useable for all staff throughout Sussex Partnership. That’s why we will ask you for your input. These are values and behaviours for us all, informed and led by us all.

We want to discuss the idea of adopting the NHS constitution values. Over the next six months (April – September 2015) we’ll be talking to staff, patients, public and partners about what this would mean in practice and how you would notice. This will help us develop the ‘behaviours’ you would expect to see from everyone who works here.

In Autumn 2015 we will release our new values and behavioural expectations of all staff at Sussex Partnership to lead our organisation to provide consistently ‘excellent care and treatment you can be confident in.’
SUMMARY & PURPOSE

There is a statutory requirement for all NHS Trusts to produce an annual Quality Account. For NHS Foundation Trusts this has to be incorporated into a Quality Report. This must follow detailed requirements set out by Monitor. The final report must be published on the NHS Choices web site by the end of May 2015.

Part 1 of the Quality Report is a statement on quality from the chief executive. This will be included in the final version which has to be approved by the Board of Directors in May 2015.

Part 2.1 sets out the quality improvement priorities for the coming year (2015/16). These are also included in the annual plan for 2015/16. The final draft that will be considered by the Board of Directors in April is attached. Feedback from many stakeholders, including from Governors on 9th February, has been most helpful in setting the quality improvement priorities for next year. For example there are priorities relating to:

- making sure that actions from serious incident reviews and audits are completed so that change takes place
- physical and mental health care (Parity of Esteem)
- reducing readmissions to hospital
- experience of people who use services, carers and staff

Parts 2.2, 2.3 and Part 3 are in the process of being drafted. They will form the major part of the draft Quality Report that will be issued for consultation on 10 April with feedback required by 15 May. The lead CCG (West Sussex Coastal are obliged to comment. Other stakeholders such as HealthWatch and local authority scrutiny committees will be invited to comment. **The Council of Governors is also invited to comment and the draft Quality Report will be circulated on 10 April.** All comments will be included in the Quality report at Annex 1.

The Quality Report will be subject to external audit by PWC. They will check that the report is compliant with Monitor’s requirements. They will also do in depth work to check the accuracy of reporting against two nationally selected indicators (7 day follow ups and gatekeeping admissions to hospital) and one that is locally set by Governors. Discussions are continuing with the auditors to select the local indicator.

SPECIFIC POINTS FOR GOVERNORS

The content and format of the Quality Report are set in Monitor’s requirements. The Trust will publish a summary report that can be accessed by the general public.
across the South East.

Part 2.2 gives a series of statements of assurance from the Board. Governors are asked to note the range of clinical audit work that has taken place over the last year.

Part 2.3 if the report against core indicators. Governors will note that these indicators are included in regular performance reports to the Council and the Board of Directors.

Part 3 gives a narrative on how well the Trust has performed against the quality improvement priorities set last year. Comments are welcome.

It would be most helpful if Governors could give views on the issues that should be highlighted in the summary report for the general public.

**ACTION REQUIRED BY COUNCIL MEMBERS**

Governors are asked to:

1. Note the quality improvement priorities for 2015/16.
2. Comment on the draft Quality Report for 2014/15 once circulated. These comments will be included in Annex 1 of the Quality Report.
Quality improvement priorities 2015/16

We have consulted with a range of stakeholders including local and national commissioners, service user and care organisations, HealthWatch, local authority scrutiny committees, our Governors and our staff. People have told us that we should improve quality in ways that make a noticeable, and measurable, difference to the people using those services. We will also ensure we continue to improve quality so that we meet the Fundamental Standards set by the Care Quality Commission.

Making sure that our services are safe is the top priority. We have joined a growing number of mental health trusts in the Sign up to Safety campaign.

The experiences of people who use our services, carers and our staff are critical to delivering high quality services. We have consulted on the improvements that would make the most difference for people and these are specified below. In particular we aim to see significant improvements in the way that people are involved in their care and the way care is recorded through the introduction of the new Carenotes system.

People who use our services are significantly more likely than the general population to die prematurely. We can begin to change this by making sure that people using our services have good physical health care that promotes their health and well-being. We have also been asked to have additional focus on crisis care. Last year we completed a large number of clinical audits. Our stakeholders are keen for us to demonstrate that we act on the findings and make a difference to service quality.

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<tr>
<th>Sign up to Safety</th>
<th>Our quality priorities and why we chose them.</th>
<th>What will success look like?</th>
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<tr>
<td></td>
<td>We have joined the national campaign and have made the following pledges:</td>
<td>Effective and efficient incident reporting ensuring that learning and improvement is embedded as a result</td>
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<td>1. <strong>Put safety first.</strong> Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.</td>
<td>Building on our work as one of the national pilot sites, we will use the Mental Health Safety Thermometer on all wards (this includes asking patients if they feel safe).</td>
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<td>2. <strong>Continually learn.</strong> Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.</td>
<td>Meeting national best practice standards on timely completion of final Serious Incident investigation, reports, and learning.</td>
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<td>3. <strong>Honesty.</strong> Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.</td>
<td>Clear evidence of genuine candour and learning.</td>
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<td>4. <strong>Collaborate.</strong> Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.</td>
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<td>5. <strong>Support.</strong> Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.</td>
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We will publish a safety improvement plan by 1 May 2015. This will include areas of concern noted by CQC and other stakeholders.
We will improve effective incident reporting, learning and publicizing the findings, and taking action to improve safety.

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<tr>
<th>Improving experience for people who use our services</th>
<th>Feedback from our 2020 Vision workshops, governors, HealthWatch and other stakeholders has told us that we need to improve care planning. This means people being engaged and involved in the process. Agreeing how the Trust will improve the process of care planning and designing the forms within CareNotes to support and measure this.</th>
<th>Proportion of actions from Serious Incident reports signed off as completed. (note link to audit tracker and re-audits)</th>
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<tr>
<td>Improving experience for carers of people who use our services</td>
<td>Over the last year we have continued to implement the Triangle of Care – the relationship between people who use our services, their carers and our staff. We will improve the way we listen all three groups of people. We will demonstrate how our approach to carers has improved as a result.</td>
<td>Ensuring that all letters to GPs about individual patients are shared with the individual too (repeat audit). Increase in the proportion of people who report that they have a copy of their care plan and feel involved in planning their care (Friends and Family, Annual Community Mental Health Survey).</td>
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<td>Improving experience for our staff</td>
<td>If staff feels engaged, and we listen to them, they are supported to provide better care for people. We have signed up to the Listening into Action Campaign. We plan to see an improvement in staff engagement.</td>
<td>Measure to be agreed with carers groups before the end of March.</td>
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**Effectiveness 1**

People with mental health, learning disability and substance misuse problems, on average die younger than the rest of the population. The Parity of Esteem campaign promotes people’s physical health. We aim to see measurable improved physical health for people using our services.

Increase the use of MEWS (Medical Early Warning Signs) and taking action (repeat audit).

**Effectiveness 2**

Next year we plan to improvement the crisis care pathway by continued local implementation of the Crisis Care Concordat. We will work closely with other agencies, including Sussex Police.

Reduction in readmissions to hospital within 28 days of discharge.

**Effectiveness 3**

We have implemented a tracking system to check that SMART actions following clinical audits are agreed, owned and implemented by a specified date. In this way we can be sure that services learn and improve.

Proportion of actions signed off as completed.

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We have been asked to include outcome indicators in our quality improvement priorities for 2015/16. The new electronic patient record system (CareNotes) will come on stream this
Another area of concern for stakeholders is timely access to services and treatment, especially for children and young people. We will continue to work with our commissioners to make sure there is sufficient funding and that we provide an efficient and effective service. An improvement indicator for Sussex Partnership alone would be unhelpful. We can only improve access by working with our commissioners and all the other agencies involved in providing care. We are committed to doing this.

The risks to successful delivery of these quality improvement priorities will be captured in the Board Assurance Framework. Regular reports are made to the Board of Directors. The key risks are:

1. The pressure on our acute mental health beds, our community services and the overall resilience of the local health and care system
2. The need to use temporary staff in areas where it is hard to recruit
3. The competing demands that our commissioners the CCGs have to balance
4. Failure to continue improving our engagement with stakeholders, people who use our services, carers and our staff.
5. Difficulties with record keeping and reporting systems as Carenotes are introduced.